STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 12/20/2011				ETED	
	NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER			10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
F0000	State Licensure included the Inv IN00100554. Complaint IN00 Federal/state de allegations are consumer included the Inv IN00100554. Complaint IN00 Federal/state de allegations are consumer included in Inv Inv Inv Inv Inv Inv Inv Inv Inv In	December 11, 12, 13, 14, 2011 : 000471 r: 155572 100290390 , RN-TC e, RN , RN 13, 14, 15, 16, and 20,	F000	00			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155572	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Other: 19 Total: 76			
	Sample: 15 Supplemental: 5 Residential: 5 Residential Supplemental: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2 Quality review completed on December 22, 2011 by Bev Faulkner, RN			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155572	B. WING			12/20/	2011
NAME OF P	ROVIDER OR SUPPLIER		<u>' </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WHILE OF T	KO VIDEK OK SOIT EIEK				1 600 E COUNTY LINE RD		
AUTUMN	HILLS HEALTH AI	ND REHAB CENTER		DEMOT	TE, IN 46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG			<u> </u>	TAG	DEFICIENCY)		DATE
F0157	•	nediately inform the					
SS=D	resident; consult w	nown, notify the resident's					
		e or an interested family					
		re is an accident involving					
		results in injury and has					
	the potential for re						
		nificant change in the					
		l, mental, or psychosocial					
	or psychosocial st	rioration in health, mental,					
	threatening condit						
complications); a need to alter treatment significantly (i.e., a need to discontinue an							
		a need to discontinue an					
	•	eatment due to adverse					
	•	to commence a new form					
	·	decision to transfer or dent from the facility as					
	specified in §483.						
	opcomed in 3 roc.	12(a).					
		lso promptly notify the					
		own, the resident's legal					
	•	nterested family member					
		ange in room or roommate ecified in §483.15(e)(2); or					
	-	ent rights under Federal or					
		ations as specified in					
	paragraph (b)(1)						
	T						
	•	ecord and periodically s and phone number of the					
		oresentative or interested					
	family member.	oresentative of interested					
\ 	•	review and interview, the	F015'	7 Ì	F 157	'	01/06/2012
	facility failed to	-			The facility is requesting pap		-
		mely manner related to a			compliance for this deficienc	у.	
		ion and medication					
	-				The filing of this plan of		
refusal for 2 of 15 residents reviewed for				correction does not constitu			
		ation in a total sample of			an admission that the allege		
	15. (Residents #	6 and #64)			deficiency exists. This plan	OT	
			1	l		l.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			` ´		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155572	B. WIN	IG		12/20/2011	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			10352 N	N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN 46310		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					correction is provided as		
Findings include:				evidence of the facility's des	•		
					to comply with the regulation	ns	
	1. Resident #6's	record was reviewed on			and to continue to provide		
	12/13/11 at 9:10	a.m. Resident #6's			quality care.		
	diagnoses includ	ed, but were not limited					
		uctive pulmonary disease,			1) Immediate actions taken fo	or	
	hypertension, an				those residents identified:	···	
	in percension, un	a dementia.			Resident #6 had treatment		
	Dragonaga mataga	n the fellowing dates and			ordered, initiated and		
	~	n the following dates and			completed per physician's		
	times indicated:				orders.		
					Resident # 64 Staff abided by	'	
	_	o.m., "Resident lung			the resident's right to refuse		
	sounds congestion	on and moistPhysician			medication. Resident		
	notified awaiting	gany new orders. No			discharged on date of last scheduled dose.		
	cough noted"				scrieduled dose.		
					2) How the facility identifie	ed	
	12/6/11 2:01 a.m	ı., "o2 (oxygen			other residents:		
	saturation) 89%	on room airResident			All residents have the		
	lungs sound cons	gestion and moist. No			potential to be affected.		
		o oxygen has been			December 2011 24 Hour		
	~	esent time. Waiting to			Reports were reviewed for		
	_	ny new orders from			changes in condition and		
	(Physician's nam	•			medication refusals to		
	(= 11) 5121411 5 114111				identify any other resident	s	
	12/7/11 at 1·26 a	.m., "Writer alerted by			that may have been		
		Medication Aide),			affected. Physicians were		
		* *			notified of identified		
	`	e) doesn't look right."			changes and refusals.		
		ed dark around the mouth					
		rations are labored 28, o2			3) Measures put into place	<i>l</i>	
	sat-88%"				System changes:		
					Licensed staff have been		
		.m., "Resident started on			re-educated on the		
	2L (liters) via ma	ask."			Physician Notification		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED)			
		155572	B. WIN	G		12/20/2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER		10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	12/7/11 at 4:17 p been on o2 (oxyg stats (sic) have s' 94%Resident i throat area and n stuffed up" 12/8/11 at 8:07 p to physician), " plan/follow-up o (antibiotic) and I (intramuscular) y During an interv (Director of Nur: 10:45 a.m., she i should have been when there was n physician. 2. Resident #64' 12/15/11 at 1:30 diagnoses includ to, hemiplegia, d hypertension. A physician's ord indicated Furose 40 milligrams IN A MAR for Decor	o.m., "Resident has not gen) during 6-2 shift o2 tayed between 91 and s very wheezy in the ose sounds like it is o.m. (3 days after first call .Treatment n treatment plan: Z-pack Depo-medrol (steroid) IM a's (times) one dose" iew with the DoN sing) on 12/13/11 at ndicated the physician in called again on 12/6/11 no response from the s record was reviewed on p.m. Resident #64's ed, but were not limited			Policy. DON or designee will audit the 24 Hour Reports to identify change in condition, medication refusals, etc and verify that physician notification has been completed. Aud of 24 Hour Reports will be completed a minimum of three times a week. Any identified discrepancies who corrected. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for three months then quarterly for 3 month Licensed Nurses identified as being non-compliant with be counseled. 5) Date of compliance: January 6, 2012	es it ill

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/20/	ETED
	PROVIDER OR SUPPLIEF	ND REHAB CENTER		10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	medication. The progress not the physician was refusal of the m days. During an interval. The physician should resident refused A facility policy Physician Notific Condition," date current from the 12:15 p.m., indicensure that medicommunicated to in a timely, efficiant manner General attending physician Response include: a. Response and the physician physician should resident refused.				CROSS-REFERENCED TO THE APPROPRIA	TE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	SURVEY .ETED			
		155572	B. WIN	LDING G		12/20	/2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER		10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0250 SS=D	The facility must procial services to highest practicable psychosocial well-Based on record facility failed to was notified for care related to be following the facility of 15. (Residents exhibits exhibits of 15. (Residents exhibits exhi	provide medically-related attain or maintain the ephysical, mental, and being of each resident. review and interview, the ensure social services assistance with planning chavior management and chility's policy for monthly ement meetings for 2 of 8 ing behaviors in a sample is #12 and #15) Est record was reviewed on a.m. Resident #12's ed, but were not limited disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions. Est (Minimum Data Set) disease, senile dementia, sorder with delusions.	F02		F250 The facility is requesting pay compliance for this deficience. The filing of this plan of correction does not constitution and admission that the alleg deficiency exists. This plan correction is provided as evidence of the facility's deto comply with the regulation and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Social Services has been noted for the behaviors and PRN psychotropic use for resident and #15 2) How the facility identified other residents: All residents with a history behavioral issues or receiven PRN psychotropic medications, will have a documentation and MAR (Medication Administration Record) review of the past days. Any identified episod a behavior or use of a PRN psychotropic medication will be referred to the social	cy. ute ed n of sire ons for fied #12 ed of e	01/06/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLET	ED
		155572		LDING	· · · · · · · · · · · · · · · · · · ·	12/20/20	11
			B. WIN		A DDDDGG GUTY GTA TO GID GODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
A 1 1 1 18 48		AND DELIAD OFNED			N 600 E COUNTY LINE RD		
AUTUMN	N HILLS HEALTH A	AND REHAB CENTER		DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	MMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	6/23/11, Remov	ve resident from source of			services director for further		
	agitation and ta	ke her to less stimulating			review and possible behavi	or	
	_	other residents and the			plan update.		
		becoming agitated.					
		resident a snack or drink.			3) Measures put into place	e/	
	•				System changes:		
		ct her to an activity			The 24 hour report will be		
	· ·	resident personal care, take			reviewed during the leaders	ship	
	to bathroom				team meeting. Episodes of		
	11/07/11, Atten	npt to determine trigger			observed undesirable		
	and eliminate if	possible			behavior as well as PRN us	se	
	11/17/11, At fir	st signs of agitation,		of psychotropic medication			
	•	t with a familiar object for			use will be discussed by the	Э	
	resident to hold				team and recorded in the		
					minutes of the meeting. The	9	
	_	in all procedures prior to			social services director will		
	beginning				provide follow up		
	11/17/11, Speak	with her in a calm			documentation as needed.		
	manner				Licensed staff have been		
					re-educated on appropriate		
	Review of the f	acility's progress notes			documentation of undesiral	ole	
		llowing behaviors:			behaviors. Behavior Team		
		p.m., the resident had			Meetings will be held month	nly	
		e resident into his room.			per facility policy.		
					Administrator or designed)	
		ote indicated the male			will audit 24 Hour Reports	а	
	-	and hit her three times in			minimum of three times p	er	
		olled newspaper.			week to ensure that		
	11/18/11 at 5:00	p.m., the resident was in			behavior documentation		
	the dining room	, approached another			has been completed		
	resident and sm	acked the resident across			properly and Social		
	the face.				Services notified.		
	The charge mass	rass notas apparmina tha			4) How the corrective		
	1 0	ress notes concerning the			actions will be monitored:		
		riors were not entered into			The results of the audits wil		
		tab of behavior data				'	
	L collection tool i	n the electronic charting	- 1		be presented to the QA		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	STREET A 10352 N	NDDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	in the resident's chart. The last behavior management team review indicated the date of 9/27/11. The last care plan conference with the resident's family, concerning the resident's behaviors was 10/25/11.		Committee monthly for three months and then quarterly. Staff identified as being non-compliant with appropriate documentation be counseled. 5) Date of compliance: 1/6/2012	
	During an interview on 12/13/11 at 11:00 a.m., the Social Services Director indicated she did not know about the resident's behaviors that were typed in the progress notes by the nurses. She indicated she looks at the behaviors that are typed on the behavior data collection tool in the assessment tab. She indicated the nurses are supposed to fill out the behavior data collection tool. She indicated she had not gotten around to having a behavior management meeting for the residents on behavior management in November as she was supposed to.			
	An undated facility policy, titled "Behavior Management Team Review," provided by the Social Service Director on 11:40 a.m., indicated, "The Behavior Management Team shall: 1. Review and discuss the efficacy of each resident's Behavior Plan on a monthly basis during the scheduled Behavior Management meeting. 2. Designated team members shall complete the Behavior Management			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155572	B. WIN			12/20/2	011
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ALITLINAN		ND DELIAD CENTED			N 600 E COUNTY LINE RD		
AUTUMN HILLS HEALTH AND REHAB CENTER			DEMOTTE, IN 46310				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	COMPLETION DATE
0		tain the completed					BIIIE
		•					
	Behavior Management Team Review form in the resident's medical record"						
	Torm in the resid	ent 5 medicai record					
	2 Resident #15'	's record was reviewed on					
		a.m. Resident #15's					
		led, anxiety, bi-polar					
	_	pecified psychosis.					
		Fr Fr. Jr					
	An annual MDS	assessment, dated					
		ted the resident was alert					
	and oriented. Th						
	assessment indic	eated the resident had					
	verbal behaviora	l symptoms directed					
	towards others.						
	Review of the re	sident's record indicated					
	the following car	re plans:					
	6/8/11, revised 6	5/9/11, Disruptive					
	behavior in grou	ps and high stimulus					
	activities at time	s will become upset and					
	• • •	t inappropriately at other					
		as a history of striking out					
		s, "1. administer meds as					
		ey acceptance of resident					
		eated honest appraisals of					
	_	ths to resident 3. discuss					
		ons of appropriate					
	_	ese feeling with resident					
	_	ident to take active social					
		ty. 4. encourage					
		problem solving skills					
	including awarer						
	directing/redirec	ting energies into					

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	of Correction identification number: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD FTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	stress-reducing activities and behaviors 5. monitor for changes in mood"			
	6/10/11, revised 6/10/11, yells out, curses, makes non-threatening statements when upset "1. provide psych care as needed, involve guardian as needed and give meds as ordered per nursing staff 2. explain his agitation may scare others 3. Notify SS (social service) of any mood/behavior indicators 4. place on 15 minute checks as needed 5. upodate (sic) MD (Medical Doctor) of increased behavior/agitation of new worsening behaviors 6. take the resident to a quiet place but do not isolate and allow him to calm 7. observe the resident for aggressive behavior red face, yelling pointing his finger, increased tone of voice 8. provide 1 on 1 as needed" 6/10/11, revised 10/31/11, yelled at another resident and their family in the dining room, has a history of physical aggression. Has told another resident "I want to kill you" 1. provide an alternate place to eat if the resident wishes 2. ask if he would like to eat in his meal in another area of the facility 3. sit resident away from residents who may annoy this resident 4. take to a quiet place and allow him to calm 5. ask the resident to use other door when exiting the dining room 6. explain the importance of respecting others. 7. impredictely congrete the			
	others 7. immediately separate the			

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	of correction (155572) To Deficiencies (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER I HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	residents if verbal or physical altercation occurs."			
	The last documented behavior management team review was dated 9/27/11.			
	A progress note, dated 11/29/11 at 1:15 p.m., indicated "Ativan (anti-anxiety) -give 0.5mg (milligrams) PRN (as necessary): resident is calm and ate lunch without incident."			
	During an interview on 12/15/11 at 10:55 a.m., the Social Service Director indicated she did not know why the resident received the Ativan. She indicated she looks only in the assessment tab. She indicated she only goes into the progress notes if she in completing a MDS assessment. She indicated the nurses were inserviced to document on the behavior data collection tool located in the assessment tab. The Social Service Director indicated "it was a problem." 3.1-34(a)			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155572	B. WIN			12/20/2011	
			J. ,, 11,	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH AN	ND REHAB CENTER			TTE, IN 46310		
					T		
(X4) ID		FATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE	
F0282		LSC IDENTIFYING INFORMATION)	 	TAG	DEI (CLERCT)	DATE	
SS=D	•	ded or arranged by the by dead by qualified persons					
33-0	•	n each resident's written					
	plan of care.	readiffediacité witten					
'	'		F02	82	F 282	01/06/2012	
	Based on record	review and interview, the			The facility is requesting pap		
		follow physician's orders			compliance for this deficienc	y.	
	*	1 2					
		ory testing for 1 of 15			The filing of this plan of		
		ed for laboratory tests in a			correction does not constitu		
	sample of 15. (Re	esident #3)			an admission that the allege		
					deficiency exists. This plan	of	
	Findings include	· ·			correction is provided as		
					evidence of the facility's des		
	1. Resident #3's	record was reviewed on			to comply with the regulatio	ns	
	12/12/11 at 11 a.:	m Resident #3's			and to continue to provide		
		ed, but were not limited			quality care.		
		owing organ transplant,					
		d hypothyroidism.			1) Immediate actions taken for	Dr.	
	hypertension, and	a hypothyroidishi.			those residents identified:	"	
		1 1 1 1 1 1 1 1 0 1 1 1			Resident #3 Transplant Team	,	
		order, dated 11/10/11,			notified of the labs that were		
		us DNA quant (test on			not drawn. Orders were		
	immunosuppress	ed individuals to check			received to decrease the		
	for viral DNA pr	esence, useful in			frequency of the lab draws		
	establishing the o	cause of allograft					
	rejection) every i	nonth.			2) How the facility identified	∤d	
					other residents:		
	The lah results d	lated 11/11/11, indicated			Labs scheduled for the pa	st	
	· ·	A quant was canceled.			30 Days have been audited	t.	
	uic Dix viius Div	A quant was canceled.			to ensure that all have bee	∤ n	
		: :4.4 D: : : 0			obtained.		
	_	iew with the Director of			The physicians will be		
	• • • • • • • • • • • • • • • • • • • •	on 12/15/11 at 8:40 a.m.,			notified of any		
		laboratory had drawn the			discrepancies.		
	BK virus DNA q	uant on Friday					
	November 11, 20	011 but it was not picked			3) Measures put into place	·/	
	up from the facil	•			System changes:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155572	A. BUI B. WIN	LDING G		12/20/2011
AUTUM	PROVIDER OR SUPPLIER	ND REHAB CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	the laboratory and 11/11 test was can had called and span 11/17 and notified was canceled similar indicated per inholes was canceled similar indicated per inholes was pecimen so that the resident's redocumentation of sent. During an interval 12/15/11 at 8:50 specimen was not be. A physician's indicated Mycophours after last downwaster last downwaster was not indicated the resident of the resident was not indicated the resident wa	cord lacked f a new specimen being liew with the DoN, on a.m., she indicated a new of obtained. order, dated 11/10/11, shenolic acid level 12 ose every week on dnesday. der, dated 10/19/11, ident was on Myfortic Sodium) sant) 720 milligrams by			DON or designee will audinew lab orders a minimum of three times a week and verify that they have been properly ordered DON or designee will audischeduled lab tests a minimum of three times poweek to ensure that they have been obtained per orders. Licensed Nurses have been re-educated on the process for ordering lab tests. 4) How the corrective actions will be monitored: Results of the audits will be presented to the Quality Assurance Committee monthly for three months and then quarterly for three months. Licensed Nurses that are identified as non-compliant will be counseled. 5) Date of compliance: January 6, 2012	t er en s

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2011	
	PROVIDER OR SUPPLIE		10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	1
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Mycopheno	lacked documentation of lic acid level to be drawn Monday and Wednesday.			
	Mycophenolic a 11/11/11 and wa The record lack Mycophenolic a 11/11/11. During an intervious 12/14/11 at 1:30	ecord indicated a acid level was drawn on as within normal range. ed any further acid levels drawn after view with the DoN, on p.m., she indicated the on 11/11/11 but none after			

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Event ID: 719511

Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155572	B. WING		12/20/2011
				T ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF I	PROVIDER OR SUPPLIEF	₹		N 600 E COUNTY LINE RD	
ALITIMAN		ND REHAB CENTER		OTTE, IN 46310	
AUTOM	THILLS HEALTH A	ND REHAB CENTER	DEIVIC	711E, IN 40310	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0309		st receive and the facility			
SS=D		necessary care and			
		or maintain the highest			
	practicable physic	cal, mental, and -being, in accordance with			
		e assessment and plan of			
	care.	c assessment and plan of			
,		review and interview, the	F0309	F309	01/06/2012
		provide the necessary	10307	The facility is requesting page	
	_	s to residents in the		compliance for this deficient	cy.
	-	o assessing an AV		The filing of this plan of	
	` ′	shunt (dialysis access)		correction does not constitu	ıte
	for 1 of 1 resider	nt who received dialysis		an admission that the alleg	ed
	(Resident #63) ii	n a sample of 15.		deficiency exists. This plan	ı of
	(Resident #63)			correction is provided as	
				evidence of the facility's de	
	Findings include	•		to comply with the regulation	ns
	i mamga meraus	•		and to continue to provide	
	1 Posidont #62	's record was reviewed on		quality care.	
		m. The resident's			
	_	led, but were not limited		1) Immediate actions taken f	or
	to, renal failure a	and diabetes mellitus.		those residents identified:	
				Resident # 63 Upon readmission to the facility th	
	A hospital, Histo	ory and Physical, dated		left A/V shunt was added to	
	09/26/11, indicar	ted the resident had a left		assessment and appropriate	
	(arm) AV shunt.			orders added to physician's	
	(ariii) 11 v Silaile.			orders.	
	A becaused disab	anna aumanami diatatad		Location and days of dialysi	s
		narge summary, dictated		were added to chart.	
	· · · · · · · · · · · · · · · · · · ·	ted the resident had a left			
	(arm) AV shunt.			Resident #6 PRN medication	
				was administered per orders	by
	Readmission Nu	rsing Observations		the QMA with authorization	
	forms, dated 09/2	28/11 and 11/08/11,		from the licensed nurse.	
	lacked document	tation to indicate the		1 6 11 11 11 11 11 11 11 11 11 11 11 11 11	.
		ft arm AV shunt.		2) How the facility identified	ea
	1001delli lidd d le	it will I i v Diluit.		other residents:	

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Event ID: 719511

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	LDING	00	(X3) DATE COMPI 12/20	LETED
	PROVIDER OR SUPPLIER	ND REHAB CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	t	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	printed on 12/15, documentation the AV shunt and was A care plan, date resident received stage renal disease included, dialysis. There was a lack resident's Nursin 10/20/11 through resident's left arm assessed. There was a lack resident's Medica Administration Ferror 11/11, and 12/11 left arm AV shur During an interval. The RN Nursin indicated there we the Left arm AV Readmission Nursing 11/12 and 11/12 could not find which shunt had been a During an interval.	ne resident had a left arm as receiving dialysis. d 04/11/11, indicated the d dialysis due to end se. The interventions is per orders. of documentation on the g Progress Notes, dated in 12/14/11 to indicate the in AV shunt had been of documentation on the ation and Treatment Records, dated 10/11, to indicate the resident's in thad been assessed. item on 12/15/11 at 8:50 resing Consultant was no documentation of		All residents have the potential to be affected residents that receive dialysis were reviewed ensure that their dialys access site was clearly identified in their medic record along with appropriate orders. Location and days of dialysis were added to charts. PRN medications admin for December were reviewed to ensure that were properly documer and needed assessment completed. Deficiencies corrected as identified 3) Measures put into playstem changes: DON or designee will at PRN medications a minimum of three times week and observe for appropriate documentation for time of administration and follow up documentation. Medical Records or designee will audit admission/re-admission charts within 72 hours the ensure that all pertinentinformation regarding dialysis are present.	to is cal nister they nted its s ace/ udit s per tion on	
		3 /		uiaiysis are present. A	ııy	

AND PLAN NAME OF AUTUMI	OF CORRECTION OF CORRECTION IDENTIFICATION NUMBER: 155572 PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 I DEMO	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	(X3) DATE SURVEY COMPLETED 12/20/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the dialysis center where the resident was receiving dialysis, indicated the AV shunt should be assessed at least one time a shift. She indicated the AV shunt especially needs assessed after dialysis to ensure there is no bleeding from the shunt. During an interview on 12/15/11 at 2:15 p.m., the RN Nursing Consultant indicated the facility did not have a policy for dialysis.		discrepancies will be corrected immediately. Licensed Nurses have be re-educated on proper completion of admission documentation. 4) How the corrective actions will be monitored Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months Nurses identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	en :

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLE	TED
		155572	A. BUII B. WIN			12/20/2	2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	-					
ALITLIMAN	I LIII I C LIEAT TH AF	ND DELIAD CENTED			N 600 E COUNTY LINE RD		
AUTUMN	I NILLS NEAL IN AI	ND REHAB CENTER		DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	•	nsure that the resident					
SS=D		ins as free of accident					
	·	sible; and each resident					
	receives adequate						
	i	s to prevent accidents.		22	 F323	\ \	01/06/2012
		ations, record review, and	F03	23	The facility is requesting pap		01/06/2012
	,	cility failed to ensure			compliance for this deficience		
		re put into place to		Compliance for this deficient		.,	
	•	alls for 3 of 11 residents			The filing of this plan of		
	with falls in a tot	al sample of 15.			correction does not constitu	ıte l	
	(Residents B, C a	and D)			an admission that the allege		
		,			deficiency exists. This plan	I .	
	Findings include	<u>-</u>			correction is provided as		
	Tindings metade.			evidence of the facility's des	sire		
	1 D 11 (D)				to comply with the regulatio		
		ecord was reviewed on			and to continue to provide		
		a.m. Resident B's			quality care.		
	diagnoses includ	ed, but were not limited			quality care:		
	to, stroke, debilit	y, and malaise and					
	fatigue.				1) Immediate actions taken for	or	
					those residents identified:		
	A quarterly MDS	S (Minimum Data Set)			Resident B Alarms had		
		d 10/13/11, indicated the			sounded with both falls, the		
	· ·	· · · · · · · · · · · · · · · · · · ·			alarms alerted staff to the are		
		t and oriented. The MDS			Floor mat placed on the floor	r	
		ated the resident required			next to his bed.		
		of one staff member for			Resident C Alarm was turned	.	
	transfers, bed mo	bility, locomotion,			on by staff.	,	
	toileting, and per	sonal hygiene. The			on by stair.		
	MDS assessment	t indicated Resident B			Resident D Alarm was turned	,	
	had falls since ad	lmission into the facility			on by staff.	1	
	and since the last	_			2,		
	and since the last	dissessment.			2) How the facility identifie	ed	
	A Call as 1.	4-4-4-2/1/11 1 1 1			other residents:		
	•	dated 2/1/11 and revised			All residents that have		
	_	ne nurse consultant,			had a fall have the potentia	al I	
	indicated "(Resid	lent's name) needs a safe			to be affected. Falls for	~·	
	environment with	n adequate lighting,			to be affected. Falls for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			A. BUILDII		NSTRUCTION 00	(X3) DATE S COMPL 12/20/	ETED
	PROVIDER OR SUPPLIEI		1	0352 N	DDRESS, CITY, STATE, ZIP CODE 600 E COUNTY LINE RD TE, IN 46310	121201	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	environment as a possible, side ra provide (Resider assistance for all daily living) 2/1 (wheelchair) on bathroom door 1 (Resident's name reach and encourse it for assistation as needed to AFO (splint) to 2/17/11, provide program to main functional status 12/12/11, Residual toileting program (Resident's name activities and to Therapy to evalual 12/12/11, keep reach 5/22/11, residual toileting program (Resident's name activities and to Therapy to evalual 12/12/11, keep reach 5/22/11, residual toileting program to main functional status 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and to Therapy to evaluate 12/12/11, keep reach 5/22/11, residual toileting program to main activities and toileting program to main activities and toileting program toileting program toileting	clear and uncluttered as ils per orders 2/1/11, ant's name) with needed ADLS (activities of /11, alarms to bed, w/c outside of room door and 1/3/11, be sure that e) call light is within rage (Resident's name) to nee as needed. remind o use call light 8/8/11, right leg when up restorative therapy stain or improve , 8/8/11, revised ent to have a scheduled ent 10/5/11, encourage e) to participate in stay on the unit 10/4/11, and treat as indicated personal items within make sure shower chair			December have been reviewed to ensure that appropriate interventions have been added after each fall. 3) Measures put into place System changes: Licensed Nurses have been re-educated on fall protochow to identify root cause and the importance of adding a new intervention aid in preventing further falls. Staff educated on the importance of making sure that alarms are in place and functioning. Nursing Assistants document placement and function of alarms every shift. Licensed Nurses will mal random checks on placement and function of alarms on each shift daily Interdisciplinary Team will review all falls within 72 hours of occurrence to ensure that the root cause has been identified and an appropriate intervention implemented. DON or designee will audiall falls to ensure that a neintervention has been implemented.	en ool, to e ad fike	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155572	B. WIN			12/20/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF P	PROVIDER OR SUPPLIEF	8			N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOTTE, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	the head the size	of a dinner plate.				
	Resident had a s	mall laceration, with a			4) How the corrective	
	hematoma the si	ze of a large marble			actions will be monitored:	
		ne visible on resident's			Results of Audits will be	
	_	dFall not witnessed"			presented to the Quality	
	right side of field	d dii not witnessed			Assurance Committee	
	Review of a post fall investigation, dated				monthly for three months	
					and quarterly for three	
	•	ted "Root cause of fall:			months. Staff that are	
		nd without assistance and			identified as being	
	fell. additional interventions: Sent for evaluation. Continue current				non-compliant in making	
					sure that alarms and safet	ty
	interventions."	The internal factors			measures are not in place	
	possibly related	to fall were forgets to call			will be counseled.	
	for assistance, la	ck of safety awareness				
	and history of w	andering were circled. It			5) Date of compliance:	
		tation if the alarms were			January 6, 2012	
	in place at the time					
	in place at the th	ne or the run.				
	During an interv	iew on 12/12/11 at 3:10				
	p.m., the DoN in	dicated there were no				
	new intervention	is added to prevent				
	further falls on 1	1/28/11.				
	A fall progress n	ote, dated 12/3/11 at				
		cated "Patient laying on				
	floor in room on					
		0				
	A post fall inves	tigation, dated 12/5/11,				
	_	cause of fall: resident				
		call light for assistance				
		self up out of bed and fell				
		eded to use the bathroom.				
		ventions: toileting every 2				
	hours, remind re	sident to use call				

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572			ULTIPLE CO LDING G	NSTRUCTION 00	(X3) DATE COMPL 12/20/	ETED
	PROVIDER OR SUPPLIEI	R ND REHAB CENTER	-	10352 N	NDDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	related to fall we awareness and fo assistance. It la	•					
	toileting schedul resident to use the	nterventions for the led and the remind ne call light had been re plan on 10/5/11 and					
		der, dated 12/09/11, al and occupational aluate and treat.					
	p.m., the Therap	riew on 12/13/11 at 8:40 by Rehab Manager mily had spoken to the me therapy order.					
	a.m., with the N DoN, the Nurse resident was diff impulsiveness at control the impu Consultant indic else but to provi DoN indicated the	riew on 12/14/11 at 8:50 urse Consultant and the Consultant indicated the ficult due to and not being able to alsiveness. The Nurse sated there was nothing de one on one care. The he facility had not put in as in place after the fall on					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/20	LETED
	PROVIDER OR SUPPLIER	I : ND REHAB CENTER	B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Fall Investigation indicated "4. (Investigation a. I to prevent furthe with new interve 2. During an obs 4:13 p.m., with I laying in bed. The not turned on. It is sensor bed alarm time of the observation of the observat	mplement interventions or falls. Update care plan intion" Servation on 12/11/11 at LPN #1, Resident #C was the sensor bed alarm was PN #1 acknowledged the awas not turned on at the evation. Cord was reviewed on p.m. The resident's ed, but were not limited hypertension. Day MDS (Minimum ment, dated 10/31/11, ident had falls prior to into the facility. Atted 12/05/11, indicated a potential for falls. The luded, an alarm to the elchair. Faluation, dated 12/02/11, ident was a high risk for the form of 17. The evaluation ident had two or more					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155572	B. WIN			12/20/	/2011
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
A T		AND DELIAD CENTED			N 600 E COUNTY LINE RD		
		AND REHAB CENTER			TE, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
ind	†	larm Assessment, dated		1110			DATE
		ated the resident tries to					
	· ·	nsafely and tries to stand,					
	_	alk alone. The assessment					
	•	sident required a personal					
	alarm.	a personal					
	3. During an ol	oservation on 12/11/11 at					
	_	RN #2 present, Resident					
	_	m her wheelchair, which					
		he Nurses' Station, and					
	ambulated 1/2 way to the Nurses' Station.						
	The resident's v	wheelchair alarm did not					
	activate.						
	During an inter	view at the time of the					
	observation, RN	N #2 indicated the					
	resident's chair	alarm was not turned on.					
	Resident # D's 1	record was reviewed on					
	12/12/11 at 2:5:	5 p.m. The resident's					
	diagnoses inclu	ded, but were not limited					
	to, Alzheimer's	Disease and dementia.					
	The resident's (Quarterly MDS assessment,					
	dated 10/25/11,	indicated the resident had					
	two or more fal	ls without injury since the					
	last MDS asses	sment had been					
	completed.						
		lated 02/15/11, indicated					
		s a risk for falls, related to					
	1	s. The interventions					
	included an alar	rm to the resident's chair.					

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PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00 	COMPLETED 12/20/2011		
	ROVIDER OR SUPPLIER	ND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	11/03/11, indicat alarm to the residuheelchair. The Progress No 5:37 p.m., indicat out of the wheelchair.	ary Team note, dated ed to continue with the dent's bed and tes, dated 11/26/11 at ted the resident had slid chair in the dining room.					

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Event ID: 719511

Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	A. BUILDING			ETED
		155572	B. WING			12/20/	2011
			_	ET ADDRESS CITY	Y, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				UNTY LINE RD		
AUTUMN	I HII I S HEAI TH AN	ND REHAB CENTER		OTTE, IN 4631			
					. •		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		DER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY		DATE
F0329 SS=D		ug regimen must be free drugs. An unnecessary					
33-0		hen used in excessive					
		plicate therapy); or for					
		n; or without adequate					
		out adequate indications					
	for its use; or in the	e presence of adverse					
	•	ich indicate the dose					
		l or discontinued; or any					
	combinations of th	e reasons above.					
	Rased on a compr	ehensive assessment of a					
	·	y must ensure that					
		e not used antipsychotic					
	drugs are not give	n these drugs unless					
		therapy is necessary to					
	•	ndition as diagnosed and					
		e clinical record; and					
		antipsychotic drugs ose reductions, and					
	-	ntions, unless clinically					
		an effort to discontinue					
	these drugs.						
	Based on record	review and interview, the	F0329	F329			01/06/2012
		ensure interventions were		The facility	y is requesting pap	er	
	_	o giving a PRN (as		complianc	e for this deficienc	y.	
		ety medication for 1 of 5					
	,	ed for PRN antianxiety		_	of this plan of		
		,			does not constitu		
		total sample of 15.			sion that the allege		
	(Resident #19)				exists. This plan	ot	
					is provided as		
	Findings include	:			of the facility's des		
					with the regulatio	ns	
	1. Resident #19'	s record was reviewed on			ntinue to provide		
	12/15/11 at 9:20	a.m. Resident #19's		quality car	re.		
		ed, but were not limited					
	_	isease, congestive heart		1) Immedia	ate actions taken fo	nr l	
	failure, and anxie			, ,	dents identified:	··	
	ianure, and anxie	ειy.			#19 had no adverse	,	
				1.00100110#		•	

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Event ID: 719511

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		LDING	00	(X3) DATE SU COMPLET 12/20/2	TED
	ROVIDER OR SUPPLIER	ND REHAB CENTER	<u> </u>	10352 1	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated Xanax	der, dated 10/4/11, (antianxiety medication) by mouth 2 times a day			effects from the administrat of Xanax. 2) How the facility identified the residents:		
	A November 201	1 MAR (Medication Record) indicated Xanax			All residents that receive PRN psychotropic medications have the potential to be affected. Residents that received		
	a.m., indicated X "nervious (sic) rail," but lacked	dated 11/6/11 at 2:09 fanax was given due to resident. shaking bed documentation of d prior to giving the			PRN psychotropic medications in the month of December have been reviewed to ensure that documentation of non-pharmaceutical		
	p.m., indicated X	dated 11/25/11 at 8:05 Canax was given but ventions tried prior to			interventions were documented. All were reviewed for any adverse effects from the administration of the prn psychotropic medication.		
		1 MAR indicated Xanax			Measures put into place System changes: Licensed Nurses re-educated on proper		
	p.m., indicated "given for agitatic and down from b	dated 12/10/11 at 9:32one prn 0.25 xanax on. resident has been up ded to wheelchair and			documentation for use of PRN psychotropic medications. DON or designee will aud PRN psychotropic		
	wheelchair and v 5 to 10 minutes a wheelchair" T	ninutes. will get up in want back into bed within and same when in bed to he progress note lacked f any interventions tried			medication use a minimu of three times per week to ensure that interventions prior to administration of PRN psychotropic		

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		DER/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHA	B CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BI REGULATORY OR LSC IDENTI	E PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	prior to giving the Xanax. A care plan, "Resident recantianxiety medications as 6/23/11, indicated "Interto provide other interventing giving antianxiety medical. During an interview with Consultant, on 12/15/11 as he indicated the nurses slathe progress note about be interventions tried before medication. During an interview with Consultant, on 12/15/11 as he indicated there were minterventions documented Xanax being given on tho 3.1-48(a)(4)	the RN Nursing to 10:45 a.m., nould write in chaviors and giving a PRN the RN Nursing to 10:55 a.m., ot any prior to the	TAG	medication have been documented. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Nurses identified as being non-compliant with the counseled. 5) Date of compliance: January 6, 2012	DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	COM	TE SURVEY MPLETED 20/2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER	103	EET ADDRESS, CITY, STATE, ZIP 852 N 600 E COUNTY LINI MOTTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
F0354 SS=C	(d) of this section, services of a regist consecutive hours Except when waiv (d) of this section, a registered nurse nursing on a full till. The director of nurcharge nurse only average daily occuresidents. Based on record facility failed to building for at led day for 2 days outhe potential to a Findings include 1. Nursing Staff the DoN (Director through 12/11/11 RN coverage for and 11/6/11. During an intervial 12/13/11 at 10:30 is running ads considered the services of the services o	rsing may serve as a when the facility has an upancy of 60 or fewer review and interview, the have a RN present in the ast 8 consecutive hours a at of 37 days. This had ffect 62 of 62 residents.	F0354	F354 The facility is request compliance for this of the filing of this plate correction does not an admission that the deficiency exists. To correction is provide evidence of the facility to comply with their and to continue to propose those residents idented an additional RN was week prior to survey 2) How the facility other residents: No residents were 3) Measures put in System changes:	deficiency. In of I constitute the alleged This plan of the das fility's desire regulations provide staken for tiffied: as hired the filitied affected.	01/06/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011		
	ROVIDER OR SUPPLIER I HILLS HEALTH AI	ND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Facility will continue to advertise and make every effort to hire and maintain adequate number of RN to have RN coverage for eightours a day seven days poweek.	o nt		
				4) How the corrective actions will be monitored: Status of RN coverage and strategies being utilized to obtain adequate RN coverage will be presented to the Quality Assurance Committee monthly for three months and quarterly until adequate RN staffing achieved and maintained. 5) Date of compliance: January 6, 2012	d d ly		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	
		155572	B. WIN	G		12/20/	2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER		10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0385 SS=D	A physician must puriting a recomme be admitted to a faremain under the care of each reside physician; and and the medical care of attending physician. Based on record facility failed to a provided medical related to the residence of the resid	personally approve in endation that an individual acility. Each resident must care of a physician. Insure that the medical ent is supervised by a other physician supervises of residents when their is unavailable. In the physician supervises of residents when their is unavailable. In the physician supervises of residents when their is unavailable. In the physician supervises of resident ident's physician not be facility staff phone call in condition of a resident,	F03		F385 The facility is requesting pap compliance for this deficience. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan correction is provided as	y. te ed of	01/06/2012
	total sample of 1. Findings include 1. Resident #6's	,			evidence of the facility's des to comply with the regulation and to continue to provide quality care. 1) Immediate actions taken for those residents identified:	ns	
	diagnoses includ	ed, but were not limited active pulmonary disease,			Resident #6 Treatment was obtained, initiated and completed per physician's orders.		
	times indicated: 12/5/11 at 4:02 p sounds congestion	n the following dates and n.m., "Resident lung on and moistPhysician gany new orders. No			2) How the facility identified other residents: All residents have the potential to be affected. 2de Hour Reports for December have been reviewed for changes of condition,	4	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DUMBNIC 00			(X3) DATE SURVEY COMPLETED		
AND TEAN	or condition	155572		LDING		12/20/	
		10007.2	B. WIN		ADDRESS STATE ZID CODE	12/20/	2011
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD		
AUTUMN	N HILLS HEALTH /	AND REHAB CENTER			TTE, IN 46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	10/6/11 2:01				physician notification and timeliness of physician	ı	
		m., "o2 (oxygen			response. Letter sent to		
		on room airResident			facility physicians inform	ina	
		ngestion and moist. No			them of the expectation of	_	
		lo oxygen has been			response time to changes		
	_	resent time. Waiting to			condition.		
		any new orders from					
	(Physician's nar	ne)"			3) Measures put into plac	e/	
					System changes:		
	12/7/11 at 4:26 a.m., "Writer alerted by QMA (Qualified Medication Aide),				Staff re-educated on the		
					Change of Condition		
	`	me) doesn't look right."			Policy. Physicians notifie	ed	
		red dark around the mouth			that a timely response is		
	and eyes. Resp	irations are labored 28, o2			required for all changes i	n	
	sat-88%"				condition.		
					DON or designee will aud		
	12/7/11 at 4:30	a.m., "Resident started on			24 Hour Reports a minim	um	
	2L (liters) via n	nask."			of three times per week		
					Changes in condition will	be	
	12/7/11 at 4:17	p.m., "Resident has not			identified and physician notification and response		
	been on o2 (oxy	ygen) during 6-2 shift o2			will be verified.	;	
	stats (sic) have	stayed between 91 and			will be verified.		
	94%Resident	is very wheezy in the			4) How the corrective		
	throat area and	nose sounds like it is			actions will be monitored	:	
	stuffed up"				Results from audits will b		
					presented to the Quality		
	12/8/11 at 8:07	p.m. (3 days after first call			Assurance Committee		
	to the physician	1 \			monthly for three months	;	
	1	on treatment plan: Z-pack			and quarterly for three		
					months. Nurses identifie		
		x's (times) one dose"				/ill	
		•			be counseled.		
	During an inter	view with the DoN			E) Date of a survivous		
	_	rsing) on 12/13/11 at			ο Date of compliance:		
	(antibiotic) and (intramuscular) During an inter	Depo-medrol (steroid) IM x's (times) one dose"			months. Nurses identifie as being non-compliant was be counseled. 5) Date of compliance:		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	LDING	NSTRUCTION 00		SURVEY LETED 1/2011
		ND REHAB CENTER	10352 N	DDRESS, CITY, STATE, ZIP COD I 600 E COUNTY LINE RI TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	did not respond t	indicated the physician antil 12/8/11 to the enotification of 12/5/11.		January 6, 20	12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	BUILDING 00		COMPLI	ETED
		155572	B. WIN	G		12/20/	2011
	PROVIDER OR SUPPLIER			10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD		
AUTUMI	N HILLS HEALTH AI	ND REHAB CENTER		DEMO	ΓΤΕ, IN 46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
	ļ	<u> </u>	+	TAG	DLI ICILICE I		DATE
F0425 SS=D	The facility must pemergency drugs residents, or obtain agreement describ part. The facility in personnel to admin permits, but only usupervision of a lice. A facility must proviservices (including the accurate acquant administering biologicals) to memorate acquant administering biologicals) to memorate acquant administering biologicals of a licenterior provides consultated provision of pharm. Based on record facility failed to amount of medical the pharmacy, repreceiving a dose by the physician reviewed for receival acquain reviewed for re	rovide routine and and biologicals to its in them under an bed in §483.75(h) of this may permit unlicensed inister drugs if State law ander the general bensed nurse. In the procedures that assure in the needs of each in grocedures that assure in the needs of each in the sed pharmacist who in on all aspects of the nacy services in the facility. The review and interview, the ensure an adequate ation was received from lated to 2 residents not of medication as ordered for 2 of 15 residents eiving medications in a desidents #15 and #21)	F04	25	F425 The facility is requesting pap compliance for this deficience. The filing of this plan of correction does not constitu an admission that the allege deficiency exists. This plan correction is provided as evidence of the facility's desto comply with the regulatio and to continue to provide quality care.	ey. Ite ed of sire	O1/06/2012
	to, bi-polar disea A physician's orc	se and anxiety.			Immediate actions taken for those residents identified: Resident #15 Physician notified of missed dose of Zyprexa.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE			(X3) DATE SURVEY
ANDILAN	OF CORRECTION	155572	A. BUILDING 12/20/2011			
		100012	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/20/2011
NAME OF I	PROVIDER OR SUPPLIE	R			N 600 E COUNTY LINE RD	
AUTUMN	N HILLS HEALTH A	ND REHAB CENTER			TE, IN 46310	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	Resident # 21 Physician	DATE
	(milligrams) tab	let orally every morning"			notified of missed dose of	
	D	1.4.1.10/22/11			Prednisone	
		ress note, dated 10/23/11,			2) How the facility identifie	ed
		exa-give zyprexa 2.5 mg			other residents:	
	orally everyday:	drug unavailable"			All residents have the	
		12/12/14			potential to be affected.	
		12/15/11 at 8:40 a.m.,			Audit of medication and	
		ed the resident had not			treatment carts was	
received the Zyprexa. 2. Resident #21's record was reviewed on					conducted to ensure that	
					supply of each medication	l
					was present. All	
		p.m. Resident #21's			medications that needed t be reordered have been	°
	_	led, but were not limited			reordered.	
	_	entia with behavior			reordered.	
	disturbance, and	hypertension.			3) Measures put into place	
					System changes:	71
		2011, physician's orders			Licensed Nurses and QMA	\s
	indicated, "Pred	nisone 5 mg tablet orally			re-educated on the	
	once a day."				importance of reordering	
					medications timely and	
	A progress note	, dated 11/27/11, indicated			administering all	
	the resident did	not receive the daily dose			medications as ordered ar	nd
	of 5 mg of predi	nisone due to the			the proper manner to hand	dle
	medication was	not in from the pharmacy.			missing doses of	
					medication.	
	During an interv	view on 12/16/11 at 8:40				
	a.m., the DoN ir	ndicated she did not know			DON or designee will audi	I
	why the medicat	tion was not available.			MARs a minimum of three	
					times per week to ensure that all medications have	
	3.1-25(a)				been administered as	
					ordered.	
					O GO	
					4) How the corrective	
					actions will be monitored:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	ROVIDER OR SUPPLIER	10352 DEMO	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
			Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Nurses that are identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET	
		155572	B. WIN			12/20/20	J11
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER			N 600 E COUNTY LINE RD FTE, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	FICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0505 SS=D	physician of the fir	romptly notify the attending ndings.					
	Based on record	review and interview, the	F05	05	F505		01/06/2012
	facility failed to	promptly notify residents'			The facility is requesting pap		
	physicians of lab	oratory results for 1 of 15			compliance for this deficienc	y.	
	residents reviewe	ed for laboratory results			The filing of this plan of		
	and physician's n	otification in a sample of			correction does not constitu	ite	
	15. (Residents #	5)			an admission that the allege	ed	
					deficiency exists. This plan	of	
	Findings include	:			correction is provided as		
					evidence of the facility's des		
	Resident #5's rec	ord was reviewed on			to comply with the regulatio	ns	
	12/13/11 at 1:40	p.m. Resident #5's			and to continue to provide		
	diagnoses includ	ed, but were not limited			quality care.		
	to, hypercholeste	erolemia, spontaneous					
	ecchymoses, and	-			Immediate actions taken for those residents identified:	or	
	TI D 1 0	011 1 1			Resident # 5 Results were		
		011, physician's orders			obtained, physician notified	of	
	(recap), indicated	•			results and no new orders we	ere	
	-	C (complete blood count),			given.		
	*	abolic profile),SGOT			2) How the facility identifie	,	
	*	ood test), SGPT (liver			2) How the facility identified other residents:	;u	
		est), liver function, every			All residents that have		
	3 months."				labs ordered have the		
	D 11 . "51 1	1 1			potential to be affected.		
		ctronic record and paper					
		cumentation the facility			3) Measures put into place	e/	
		resident's physician of the			System changes:		
	abnormal lab res	ults for August 2011.			Licensed Nurses have		
					been re-educated on the		
	_	iew on 12/15/11 at 2:25			proper procedure for lab		
	* 1	Consultant indicated the			result process.		
		in the portal" (a link to			All ordered lab tests will b	I .	
	access laboratory	results from the facility)			reviewed and charts audit	ed	

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If continuation sheet

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	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 1	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and she had called the lab. She indicated the facility had not notified the physician of the lab results but the laboratory had sent the physician the results. 3.1-49(f)(2)		to ensure that all results were received and notified to the physician. DON or designee will audiordered labs a minimum of three times per week to ensure that physicians habeen notified of results. Any discrepancies will be corrected immediately. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for three months and quarterly for three months. Staff that are identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	it of ve

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155572		LDING		12/20/	/2011
		100072	B. WIN			12,20,	2011
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	AND REHAB CENTER		DEMO	TTE, IN 46310		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC .	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0507	The facility must	file in the resident's clinical					
SS=D	record laboratory	reports that are dated and					
	contain the name	and address of the testing					
]	laboratory.		l		Į		
	Based on record	I review and interview, the	F05	507	F507		01/06/2012
	facility failed to	ensure residents'			The facility is requesting par		
	laboratory repor	ts were in the residents'			compliance for this deficient	;y.	
		ds for 2 of 15 residents			The filing of this plan of		
		os in a sample of 15.			The filing of this plan of correction does not constitu	ıto	
	(Residents #5 ar	-			an admission that the allege		
		iid #21)			_		
					deficiency exists. This plan	i Oi	
	Findings include	e:			correction is provided as	-:	
					evidence of the facility's de		
	1. Resident #5's	record was reviewed on			to comply with the regulation	ns	
	12/13/11 at 1:40	p.m. Resident #5's			and to continue to provide		
		ded, but were not limited			quality care.		
	•	·					
		erolemia, spontaneous					
	ecchymoses, and	d anemia.			1) Immediate actions taken for	or	
					those residents identified:		
	The December 2	2011, physician's orders			Resident # 5 Copy of results		
	(recap), indicate	ed "Digoxin level,			placed on chart. Resident #21 Copy of results		
	cholesterol CB0	C (complete blood count),			placed on chart.	,	
	1	tabolic profile),SGOT			placed on chart.		
	`	blood test), SGPT (liver			2) How the facility identifie	ad	
	`	**			other residents:	, u	
		test), liver function, every			All residents have the		
	3 months."						
					potential to be affected.		
	Resident #5's el	ectronic record and paper			0) 84	_ ,	
	record lacked do	ocumentation of the lab			3) Measures put into place	} /	
	results for Augu				System changes:		
	1 1 2 3 dies 101 7 tagu	2011.			Licensed staff have been		
	Duning a see inter	view on 12/15/11 -4 2-25			re-educated on the proces	S	
	_	view on 12/15/11 at 2:25			for handling lab results.		
	1 *	s Consultant indicated the			DON or designee will audi	t	
		e in the portal" (a link to			lab orders and results a		
	access laborator	v results from the			minimum of three times n	er	

	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility). 2. Resident #21's record was reviewed on 12/15/11 at 1:00 p.m. Resident #21's diagnoses included, but were not limited to dementia with behavior disturbance and hypertension. A physician's order indicated a pre albumin level on 12/14/11. The resident's electronic record and paper record lacked documentation of the results of the pre albumin level. During an interview on 12/15/11 at 3:05 p.m., the DoN indicated the pre albumin results were not posted in the portal. The DoN indicated she called the lab and the lab had the results but had a problem getting the results in the portal. She indicated "there had been a problem and they were in the process of fixing it." 3.1-49(f)(4)		week. Audit of past 30 day of labs has been complete to ensure that results are present in the medical record. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months Nurses identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	ed .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155572	B. WIN			12/20/	2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
ALITLIMAN		ND REHAB CENTER			TTE, IN 46310		
	THILLS HEALTH AI	ND REHAB CENTER		DEIVIO	11E, IN 40310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	↓	TAG	DEFICIENCY)		DATE
F0513		le in the resident's clinical					
SS=D		dated reports of x-ray and					
ļ	other diagnostic se			1.0	====	ļ	01/06/0010
		review and interview, the	F05	13	F513		01/06/2012
	_	ensure a resident's x-rays			The facility is requesting pap compliance for this deficience		
	were in the reside	ent's clinical records for 1			compliance for this deficient	y.	
	of 15 residents re	eviewed for x-ray results			The filing of this plan of		
	in a sample of 15				correction does not constitu	te l	
	•				an admission that the allege		
	Findings include				deficiency exists. This plan		
	i mamgs merade	•			correction is provided as	0.	
	1 D 1 1 Dl				evidence of the facility's des	sire	
		ecord was reviewed on			to comply with the regulatio		
		a.m. Resident B's			and to continue to provide	110	
	diagnoses includ	ed, but were not limited			quality care.		
	to, stroke, debilit	y, and malaise and			quanty care.		
	fatigue.						
					1) Immediate actions taken for	or	
	Resident B's reco	ord indicated the resident			those residents identified:		
		3/11, 4/14/11, and			Resident B CT scans were		
		ecord indicated the			obtained from the hospital ar		
					placed in his medical record.		
		sent to the hospital for					
	evaluation and tr	eatment on the above			2) How the facility identified	ed	
	dates.				other residents:		
					All residents have the		
	The resident's ele	ectronic record and paper			potential to be affected.		
	record lacked do	cumentation of the			Residents that were sent		
	results of the CT				out of the facility for		
		ns completed at the			assessment during		
	hospital for 2/23/	•			December have had charts	6	
	11/28/11.	11, ¬/1¬/11, and			reviewed, diagnostic resul	ts	
	11/28/11.				that were not found in		
					charts have been requeste	ed	
	_	iew on 12/12/11 at 3:10			from the hospitals.		
	p.m., the Directo	r of Nursing indicated					
	the CT-scans we	re not in the resident's			3) Measures put into place	/	

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	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	record. The CT-scans were faxed from the hospitals on 12/13/11 at 8:51 a.m., and 9:00 a.m., and were received on 12/13/11 at 9:15 a.m., from Medical Records. 3.1-49(j)(4)		System changes: Licensed Nurses have bee re-educated on the need to request copies of lab and diagnostic results when residents are sent out to thospital for evaluation. Medical Records will request copies of lab and diagnostic results from the hospital within 72 hours of trip to the hospital. DON designee will audit for lab and diagnostic results weekly for residents that have been sent out of the facility for evaluation or testing. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months Nurses identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	he e of or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155572	B. WIN			12/20/	2011
		ND REHAB CENTER		10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0514 SS=D	each resident in a professional stand complete; accurate accessible; and sy The clinical record information to ider of the resident's as	naintain clinical records on eccordance with accepted lards and practices that are ely documented; readily estematically organized. I must contain sufficient ntify the resident; a record essessments; the plan of					
	preadmission scre	provided; the results of any ening conducted by the					
	State; and progress Based on record facility failed to were complete an physicians orders central lines (sur AV (Arterio-ven access), for 3 of complete and acc (Residents C, #1.) Findings include	review and interview, the review and interview, the resure medical records and accurate related to, s, hospital transfers, gically placed IV) and rous) shunt (dialysis 15 residents reviewed for recurate medical records. 5, and #63)	F05	14	The facility is requesting pap compliance for this deficience. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan correction is provided as evidence of the facility's desto comply with the regulation and to continue to provide quality care.	te ed of	01/06/2012
	12/15/11 at 9:55 diagnoses includ to, anxiety and b A physician's PR medication order "Ativan (anti-anx 0.5 mg (milligran There was a lack				1) Immediate actions taken for those residents identified: Resident # 15 Order for PRN Ativan has been clarified to include the frequency of use. Resident # 63 Left AV shunt added to chart when he was readmitted. Also upon readmission his central line was added to the chart. Copi of documentation about the removal of resident's IJ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2011	
	PROVIDER OR SUPPLIER	ND REHAB CENTER	STREET 10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	During an interv a.m., the Directo	iew on 12/16/11 at 8:40 or of Nursing (DoN) d "corrected the order for	TAG	catheter placed in his medicate record. Resident C Late entry made responsible nurse regarding her assessment and sending resident to the emergency room. 2) How the facility identified other residents: All residents have the potential to be affected. Pharmacy audited resident orders for December. Orders clarified as indicated. Residents admitted in December with IV access receiving dialysis charts reviewed for appropriate orders. Identified issues corrected. 3) Measures put into place system changes: Licensed Nurses re-educated on Admission assessments, Physicians orders, change in condition and transfer documentation DON or designee will reviewed three times per week to	by ed or or ew m
				identify residents with nev	v

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155572	B. WIN			12/20/2011
	PROVIDER OR SUPPLIEI	ND REHAB CENTER		10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	2. Resident #63 12/14/11 at 10 a diagnoses include to, renal failure a a) A hospital, H 09/26/11, indica (arm) AV shunt. A hospital, disch 11/09/11, indica (arm) AV shunt.	's record was reviewed on .m. The resident's led, but were not limited and diabetes mellitus. Listory and Physical, dated ted the resident had a left marge summary, dictated ted the resident had a left			orders, transfers or admission/readmission to ensure that orders are complete, transfer and an admission/readmission documentation is completed. Any deficiencies identified will be corrected. 4) How the corrective actions will be monitored: Results of audits will be presented to the Quality Assurance Committee monthly for 3 months and quarterly for three months Nurses identified as being non-compliant will be counseled. 5) Date of compliance: January 6, 2012	d de. d

	OF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	forms, dated 09/28/11 and 11/08/11, lacked documentation to indicate the resident had a left arm AV shunt.			
	The resident's current physician's orders, printed on 12/15/11, lacked documentation the resident had a left arm AV shunt and was receiving dialysis.			
	A care plan, dated 04/11/11, indicated the resident received dialysis due to end stage renal disease. The interventions included, dialysis per orders.			
	During an interview on 12/15/11 at 8:50 a.m., the RN Nursing Consultant indicated there was no documentation of the Left arm AV shunt on the Readmission Nursing Observations on 09/28/11 and 11/08/11.			
	b) A pharmacy, "Midline Catheter-Physician Order Sheet", undated, indicated the resident had a two lumen midline catheter.			
	The Readmission Nursing Observations, dated 09/28/11, lacked documentation to indicate the resident had a central line.			
	The Progress Notes, dated 09/28/11 through 10/21/11, lacked documentation to indicate the resident had a central line.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/20/	ETED	
AUTUMN	PROVIDER OR SUPPLIEI	R ND REHAB CENTER	10352 N	ODDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	dated 10/11, ind	Administration Record, icated to assess the every shift and to change ry week.				
	indicated, "D/C	rder, dated 10/20/11 (discontinue) PICC serted central catheter)				
	resident's Progre	c of documentation in the ess Notes after 10/20/11 to C had been discontinued.				
	a.m., the RN Nu indicated there v	view on 12/15/11 at 8:50 arsing Consultant was no documentation of a he resident's readmission 9/28/11				
	p.m., the RN Nu indicated she wa	riew on 12/15/11 at 2:45 arsing Consultant as not sure if the resident e or a PICC line.				
	a.m., the RN Nu indicated the res	riew on 12/16/11 at 8:30 arsing Consultant sident was sent out to a on 10/21/11 and a central inued.				
	received in the f	from the vascular clinic, acility on 12/16/11 at x, indicated the resident				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155572	B. WIN	IG		12/20/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					1 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER		DEMOT	TE, IN 46310	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGENCI	DATE
	· ·	terjugular) catheter				
	_	rogress note indicated the				
		been inserted six weeks				
	ago for antibiotic	c therapy.				
	2 Pagidant #Cla	record was reviewed on				
		p.m. The resident's				
		-				
	to dementia and	ed, but were not limited				
	to dementia and	nypertension.				
	A Progress Note	, dated 12/04/11 at 8:12				
		ne resident fell, had full				
	1 *	of the upper and lower				
	_	the fall and the resident				
	had not hit his he					
	nad not mt ms no	.au.				
	A Progress Note	, dated 12/05/11 at 2:20				
		ne nurse had spoke to the				
		resident was being				
	transferred back	_				
		-				
	There was a lack	of documentation in the				
	resident's record	to indicate the resident				
	had been transfer	rred to the hospital and				
	the reason the res	sident had been				
	transferred to the	e hospital.				
	During an interv	iew on 12/16/11 at 8:40				
	a.m., the Directo	r of Nursing indicated the				
	Progress Notes d	lid not say the resident				
	went to the hospi	ital and does not say why				
	the resident went	t to the hospital. She				
	indicated the nur	se documented the				
	information on th	ne incident report (not a				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		A. BUILDING B. WING	00 	COMPLETED 12/20/2011	
		ND REHAB CENTER	10352 1	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
TAG		nt's clinical record).	TAG	DEFICIENCY)	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155572	- 1	LDING		12/20/	2011
		.000	B. WIN			. =, = 0;	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0035		the right to the following:					
		he development of his or					
	-	nd in any updates of that					
	service plan.	P					
		ending physician and other					
		ces, including arranging for esservices unless contrary					
		ny limitation on the resident					
's right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.							
		nis or her choice, so long					
	-	ot pose a health or safety					
		staff, or visitors or a risk to					
		ohibited by facility policy.					
	_	he resident 's right to have					
	stated in the admi	choice shall be clearly					
	(4) Refuse any tre	_					
	including medicati						
	(5) Be informed of						
		a refusal under subdivision					
		data recorded in his or her					
	clinical record if tre	eatment or medication is					
	administered by th	ne facility.					
		nfidentiality of treatment.					
		efuse to participate in					
		arch. There must be					
		gement of informed					
	activities.	articipation in research					
l		rayian and interview the	 R00	125	R035	I	01/06/2012
		review and interview, the	KUC	133	The facility is requesting pap	er	01/00/2012
	<u>-</u>	have residents participate			compliance for this deficiency		
	-	ent and updates of their				-	
	-	4 of 5 residents reviewed			The filing of this plan of		
	for service plan	participation in a sample			correction does not constitu	ite	
		#101, #107. #110. and			an admission that the allege		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 50 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIΠ	ILDING	00	COMPLETED	
		155572	B. WIN		12/20/2011		
			P. ", II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			N 600 E COUNTY LINE RD		
		ND REHAB CENTER		DEMOT	TE, IN 46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE	
	#113)				deficiency exists. This plan	OT	
					correction is provided as	oiro	
	Findings include	e:			evidence of the facility's des to comply with the regulatio	I	
					and to continue to provide	1115	
	1. Resident #10	7's record was reviewed			quality care.		
	on 12/15/11 at 1	:55 p.m. The resident's			quality barb.		
	diagnoses includ	led, but were not limited					
	to, congestive he	eart failure and anemia.			1) Immediate actions take	n	
					for those residents identified	l:	
	The resident's ur	ndated, "Assessment &			Assessment & Service Plans f		
		cked documentation to			Residents #101, 107, 110 and	I	
	· ·	dent participated in the			113 were updated and reviewed with the residents on 12/15/11		
	development of				including resident signature ar		
	development of	the service plan.			date reviewed.		
	2 D	11					
		1's record was reviewed			2) How the facility		
		:20 p.m. The resident's			identified other residents:		
	_	led, but were not limited			An audit of all Assessment	&	
		and chronic obstructive			Service Plans was complete	ed	
	pulmonary disea	ise.			on 12/16/11 and all were		
					updated and reviewed with		
	The resident's, ".	Assessment & Service			residents, including residen		
	Plan", dated 08/2	24/11, lacked			signature and date reviewe	a.	
	documentation to	o indicate the resident			(a) Management work but		
	participated in th	ne development of the			3) Measures put into		
	service plan.	•			place/ System changes:		
	F				Assessment & Service Plar	ne l	
	3. Resident #11	0's record was reviewed			will be updated and reviewe	-	
		12:30 p.m. The resident's			with residents by the Direct		
		led, but were not limited			of Nursing or designee ever		
	_	al disease and bipolar.			6 months.		
	io, chu stage lell	ai discase and diputal.					
	The regidentic "	Aggagament & Carries			The Medical Records Direc	tor	
	•	Assessment & Service			will audit all Assessment &		
	Plan", dated 08/3	-			Service Plans within 72 hou	ırs	
	documentation to	o indicate the resident			of admission and every 6		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 51 of 87

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 20/2011
NAME OF PROVIDER OR SUPPLIE		STREET A 10352 I	ADDRESS, CITY, STATE, ZIF N 600 E COUNTY LIN ITE, IN 46310		
AUTUMN HILLS HEALTH A (X4) ID SUMMARY PREFIX (EACH DEFICIE TAG REGULATORY O participated in to service plan. 4. Resident #11 on 12/15/11 at 1 diagnoses inclusto, osteomyeliti The resident's, 'Plan'', dated 08/documentation participated in to service plan. During an intervice.	R AND REHAB CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) The development of the 3's record was reviewed :40 p.m. The resident's ded, but were not limited s and anxiety. Assessment & Service 31/11, lacked to indicate the resident the development of the view with the Director of 15/11 at 3:25 p.m., no	B. WING STREET A 10352 I	N 600 E COUNTY LIN	CORRECTION N SHOULD BE ILE APPROPRIATE completion en eresident. rective enitored: e audits will monthly Meeting for onths to e.	(X5) COMPLETION DATE

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 52 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPL 12/20 /	ETED
	PROVIDER OR SUPPLIER	ND REHAB CENTER	•	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R0117	qualifications, and applicable state lat twenty-four (24) he unscheduled needs services provided. qualifications, and depend on skills respecific needs of to fone (1) awakes CPR and first aid at all times. If fifty the facility regularl nursing services of medication, or bot staff person shall I Residential facilitie (100) residents regularly nursing services of medication, or bot (1) additional nursing services of medication, or bot (20) residents. Per only those duties for perform. Employed written job descriptions and CPR (cardion certificate schedulation and night shift for of schedules. Findings include Review of the nursing include	The number, training of staff shall equired to provide for the the residents. A minimum staff person, with current certificates, shall be on site (50) or more residents of y receive residential r administration of th, at least one (1) nursing the on site at all times. The swith over one hundred gularly receiving residential r administration of th, shall have at least one ting staff person awake and the for every additional fifty resonnel shall be assigned for which they are trained to the duties shall conform with tions. The review and interview, the tensure there was at least the with a current first aid pulmonary resuscitation) the for the day, evening, the residents and the staff schedules, the residents and the staff schedules, the staff schedules,	R01	17	R117 The facility is requesting pape compliance for this deficience. The filing of this plan of correction does not constitut an admission that the alleged deficiency exists. This plan correction is provided as evidence of the facility's desto comply with the regulation and to continue to provide quality care.	te ed of sire	01/06/2012

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 53 of 87

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Nursing (DoN), indicated there were no employees scheduled for duty who had both a CPR and a first aid certificate. During an interview on 12/16/11 at 10 a.m., the DoN indicated she did not realize it was a requirement to have someone with CPR and first aid certified scheduled in the building.		1) Immediate actions take No residents were cited as affected. An audit of all employee files of completed to identify staff members needing CPR and Faid certification. 2) How the facility identified residents affected: No residents were affected. 3) Measures put into place/ System changes: Licensed nurses will completed training by 1/6/12, and any nurses hired after that date will be required to complete CPR and First Aid certificat training within 90 days of hid date. Human Resources Director designee will audit all licens nurse certification files monthly to ensure that certifications are complete remain valid. 4) How the corrective actions will be monitored: The results of these audits be reviewed in the monthly	was irst ete ion e ion re or sed and

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 54 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011
AUTUMN		ND REHAB CENTER	10352 I DEMO	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				Quality Assurance Meeting a minimum of 6 months to ensure compliance.	for
				5) Date of compliance	:

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 55 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155572	A. BUII B. WIN			12/20/	/2011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
AUTUMN	HILLS HEALTH AI	ND REHAB CENTER		DEMOT	TE, IN 46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG R0148		all maintain buildings,	ļ	TAG	DEFICIENCY)		DATE
	grounds, and equi in good repair, and	pment in a clean condition, d free of hazards that may be health and welfare of the					
	residents or the pu	ublic as follows:					
	(1) Each facility sh						
	implement a writte						
	of the facility.	nsure the continued upkeep					
	(2) The electrical s	system, including					
		switches, alternate power					
		and detection systems,					
		d to guarantee safe ompliance with state					
	electrical codes.	impliance with state					
	(3) All plumbing sh	nall function properly and					
	comply with state	· · · · · · · · · · · · · · · · · · ·					
		heating and ventilating					
l	systems shall be in	nspecied.	R01	18	R148		01/06/2012
	Rasad on observe	ation, interview, and	KOI	70	The facility is requesting pap	er	01/00/2012
		e facility failed to ensure			compliance for this deficiency.		
	· ·	afe, clean and without					
	_				The filing of this plan of		
		cigarette butts in the g odor of cigarette smoke			correction does not constitu		
		nts' rooms who smoke in			an admission that the allege		
					deficiency exists. This plan correction is provided as	UI	
	a sample of 5. (R	.csideiii #101)			evidence of the facility's des		
	Findings include	:			to comply with the regulatio	ns	
					and to continue to provide		
	During an observ	vation on 12/16/11 at			quality care.		
	_	was a strong cigarette					
	· ·	he hall by Resident			1) Immediate actions taken fo	or	
		e resident's waste basket,			those residents identified:		
		nad several smoked			Cigarette butts were removed		
		the plastic garbage bag.			from Resident #101 trashcan. smoking assessment was	A	
					completed and a copy of the		
	During an intervi	iew at the time of the			smoking policy was reviewed	with	

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 56 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
		155572	B. WIN			12/20/2011
	OF PROVIDER OR SUPPLIER			10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	observation, Hor there was a smel the door of the resident shows a smel the resident shows a smell the resident sho	isekeeper #5 indicated of cigarette smoke at esident's room. She were several partial the resident's waste iew on 12/16/11 at 8:10 or of Nursing of cigarette butts in the ne stated, "guess we will him today." iew on 12/16/11 at 8:12 of 101 indicated he smokes azebo, but he brings the fter he puts them out, ility and puts them in his of the count of the puts them of the puts them of the puts them of the puts them in his of the count of the puts them in his of the puts them of the puts the pu		TAG	resident, including designated smoking areas and proper disposal of cigarette butts. 2) How the facility identified other residents: 7 residents were identified smokers. A smoking assessment was completed for each resident and the smoking policy was reviewed with each resident. 3) Measures put into place System changes: Housekeeping staff will randomly check trashcan in resident rooms during round at least 2 times per week as report any cigarette butts on strong cigarette odor in room to the Administrator. 4) How the corrective actions will be monitored: Any issues identified during rounds will be addressed immediately and discussed monthly Quality Assurance meetings for a minimum of months. 5) Date of compliance: 1/6/12	ed as ded ded ded in the control of

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 57 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011
	ROVIDER OR SUPPLIER	ND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy, as current from the titled, "Tobacco-indicated, "1. Some resident smokers smoking times	dated 04/01/10, received the Director of Nursing, Free Campus Policy", staff will supervise during designated when timer goes off all stinguished and disposed the receptacle. No partially is are to be saved"			

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 58 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPL	ETED
		155572	B. WIN			12/20/	2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
ΔΙΙΤΙΙΜΝ	I HII I S HEAI TH AN	ND REHAB CENTER			TTE, IN 46310		
	I TIILLO TILALTITAI	ND REHAD CENTER		DLIVIO			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
R0214	` '	of the individual needs of					
		I be initiated prior to					
		all be updated at least					
		upon a known substantial dent ' s condition, or more					
		nt 's or facility 's request.					
		shall evaluate the nursing					
	needs of the reside	_					
` <u>`</u>	Based on record	review and interview, the	R02	214	R214	ì	01/06/2012
	facility failed to	·			The facility is requesting pap	er	
	_	aluation for a resident			compliance for this deficienc	y.	
	•						
	,	residents reviewed for			The filing of this plan of		
		assessments in a sample			correction does not constitu	te	
	of 5.				an admission that the allege	ed	
					deficiency exists. This plan	of	
	Findings include:				correction is provided as		
					evidence of the facility's des	sire	
	Resident #107's r	record was reviewed on			to comply with the regulation	ns	
		p.m. The resident's			and to continue to provide		
		•			quality care.		
	_	ed, but were not limited					
		art failure and anemia.					
	The resident was	admitted into the facility			1) Immediate actions taken for	or	
	on 07/15/11.				those residents identified:		
					Pre-Admission assessment wa	as	
	There was a lack	of documentation in the			completed for Resident #107.		
	resident's record				2) How the facility identifie	, _d	
		een completed on the			other residents:	, u	
		being admitted into the			Circi residents.		
	•	oemg admitted litto tile			All resident files were audite	_{2d}	
	facility.				to ensure Pre-Admission	su	
					ssessments were completed	_d	
	_	iew with the Director of			No other residents were	u.	
	Nursing, on 12/1	5/11 at 3:25 p.m., no			affected.		
	further information	on was given in regard to			anecteu.		
	the pre-admission	_			3) Measures put into place	,	
	1					; <i>i</i>	
					System changes:		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 59 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	DER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155572	B. WING		12/20/2011	
	PROVIDER OR SUPPLIE	R AND REHAB CENTER	STREET 10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	Medical Records Director of designee will audit new admission charts within 72 hours of admission to ensural required assessments a paperwork are completed a filed in charts. Any deficiencies noted be corrected immediately. 4) How the corrective actions will be monitored. The results of these audits be reviewed in the monthly Quality Assurance meeting a minimum of 6 months to ensure compliance. 5) Date of compliance: 1/6/	or re nd and will : will for	

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 60 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			(X2) MULT A. BUILDI B. WING		OO	(X3) DATE COMPL 12/20 /	ETED
	ROVIDER OR SUPPLIER	ND REHAB CENTER	S 1	10352 N	DDRESS, CITY, STATE, ZIP CODE 600 E COUNTY LINE RD FE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
R0216	shall be delineated manual, but at a massessment shall following: (1) The resident's mental status. (2) The resident's activities of daily li (3) The resident's admission and ser (4) If applicable, the self-administer medical manual manua	s weight taken on miannually thereafter. He resident 's ability to edications. Is shall be documented in the facility. He review and interview, the complete a thorough the treatment of 2 residents sample of 5. (Resident of 2 resident of 3 p.m. The resident's ed, but were not limited all disease and bipolar. He readmitted into the complete into the complete of the treatment of the resident of the complete and sample of 5. (Resident of 1 disease and bipolar. He admission assessment, andicated the resident of the complete o	R0216		R216 The facility is requesting pap compliance for this deficience. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan correction is provided as evidence of the facility's desto comply with the regulation and to continue to provide quality care. 1) Immediate actions taken for those residents identified: As stated in the 2567, a Safe Smoking Assessment was completed for Resident #110 of 12/16/11. 2) How the facility identified other residents:	te ed of sire ns	01/06/2012

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 61 of 87

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	smoking at the facility. A, "Safe Smoking Assessment" form, received from the Director of Nursing on 12/16/11, indicated, "This assessment must be completed upon admission for ALL residents who wish to smoke" During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated an assessment had not been completed on the resident until 12/16/11.		All residents identified a smokers have had a Safe Smoking Assessment completed. 3) Measures put into place System changes: Social Services Director or designee will complete a Sa Smoking Assessment for residents identified as smokers upon admission, a every 6 months thereafter. Medical Records Director or designee will audit new admission charts within 72 hours of admission to ensurall required assessments are paperwork are completed a filed in charts and every 6 months thereafter. Any deficiencies noted will corrected immediately. 4) How the corrective actions will be monitored: The results of these audits be reviewed in the monthly Quality Assurance meeting a minimum of 6 months to ensure compliance.	el afe and r re and ind be
			5) Date of compliance:	

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 62 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011
AUTUMN		ND REHAB CENTER	10352 1	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				1/6/12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 00	COMPLETED
		155572	B. WING		12/20/2011
				REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		10	0352 N 600 E COUNTY LINE RD	
AUTUMN	N HILLS HEALTH AI	ND REHAB CENTER		EMOTTE, IN 46310	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION)	TA	AG DEFICIENCY)	DATE
R0217	facility, using appresent members, shall ideservices to be profollows: (1) The services or resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or and revised as appeared and revised as appeared and the resident and fact change. Either the request a service (3) The agreed upsigned and dated of the service plans resident upon request and the services provided subsequent to the noneed for a chard (5) If administration provision of reside both, is needed, a involved in identification of the services to be a service plans for infection and isoof medications, so (arterio-venous) for 3 of 5 resider	ffered shall be reviewed propriate and discussed by acility as needs or desires a facility or the resident may plan review. on service plan shall be by the resident, and a copy a shall be given to the uest. In and documentation of is needed if evaluations initial evaluation indicate ange in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation	R0217	R217 The facility is requesting pa compliance for this deficient. The filing of this plan of correction does not constit an admission that the alleg deficiency exists. This plat correction is provided as evidence of the facility's deficience of the facility of the facili	ute ged n of
	of medications, s (arterio-venous) for 3 of 5 resider plans in a sample	smoking, and an AV fistula (dialysis access) ats reviewed for service		correction does not constit an admission that the alleg deficiency exists. This pla correction is provided as	ged n of esire

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 64 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET.			ETED	
		155572				12/20/2	2011
			B. WIN		ADDRESS STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
A 1 1 T 1 18 48		ND DELIAD OFNITED			N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	: :			and to continue to provide		
	_				quality care.		
	1 During an obs	servation on 12/15/11 at					
	_	e was an isolation cart					
	outside Resident				1) Immediate actions take		
	outside Resident	. #113 \$ 100m.			for those residents identified	l:	
					Coming Diana for Desident #4	12	
		record was reviewed on			Service Plans for Resident #1 #101, and #110 were updated		
		p.m. The resident's			reflect current needs and state	I	
	diagnoses includ	led, but were not limited			Tonost surront riceds and state		
	to, osteomyelitis	and anxiety.			2) How the facility		
					identified other residents:		
	A wound culture	e, dated 12/02/11,					
		ident had methicillin			All resident Service Pla	ins	
		areus in her left leg			were reviewed for accuracy		
	_	areus in her left leg			and updated as indicated.		
	wound.						
					3) Measures put into		
		rvice plan, dated			place/ System changes:		
	08/31/11, lacked	documentation to					
	indicate the resid	dent had an infection of			Service Plan form has beer	n	
	the left leg woun	nd and was in isolation.			revised to include a section		
					"Temporary Service Issues		
	During an interv	riew on 12/15/11 at 1:55			for short term acute issues		
	_	dicated the resident was			identified.		
	1	on after the culture on					
		on after the culture on			Medical Records Director of	r	
	12/02/11.				designee will audit physicia	n	
					orders at least once per we		
		1's record was reviewed			and ensure Service Plans a		
	on 12/15/11 at 1	:20 p.m. The resident's			updated as indicated with		
	diagnoses includ	led, but were not limited			changes in plan of services		
	to, hypertension	and chronic obstructive] .		
	pulmonary disea				4) How the corrective		
	F				actions will be monitored:		
	a The regident's	"Smoking Safety					
		s, "Smoking Safety			The results of these audits	will	
	Assessment", da	ted 02/25/11, indicated			Is recalls of these addits		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 65 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155572		LDING	00	12/20/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	2			N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER			TTE, IN 46310	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710		onstrated the ability to		mo	be reviewed in the monthly	DATE
		thout supervision.			Quality Assurance meeting	for
	Surery surery without supervision.				a minimum of 6 months.	
	b. An evaluation	n of the resident's ability				
	to safely self-adı	minister medication,			5) Date of compliance: 1/6/12	
	dated 07/29/11, i	indicated, "if the nurse			1/0/12	
		ines that the resident is				
	not capable of se	_				
		plain heredue to his hx				
	(history) of alcol not feel he is saf	holism, this writer does				
	not feet he is saf	e."				
	The resident's M	edication Administration				
		2/11, indicated the				
		administering the				
	medications.	· ·				
		, dated 08/24/11,				
		ident requests staff to				
		ns, the resident will store				
		ter the medications, and the medications for the				
	resident weekly.					
	1031dont weekly.					
	The service plan	, dated 08/24/11, lacked				
	documentation to	o indicate the resident				
	smokes cigarette	es.				
	2 D 1 4 1111	01				
		0's record was reviewed				
		2:30 p.m. The resident's led, but were not limited				
	~	al disease and bipolar.				
	io, ond stage fell	ar arsease and orporar.				
	An evaluation of	f the resident's ability to				

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 66 of 87

	of correction identification number: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 12/20	LETED
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE R TE, IN 46310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	safely self-administer medication, dated 07/29/11, indicated, the resident could safely self-administer her medications.				
	Administration Record, dated 12/11, indicated the resident self-administers her medication after the staff sets up the medications weekly.				
	The service plan, dated 08/31/11, indicated, "require staff to order, store and dispense medication(s)"				
	The resident's physician's recapitulation orders, dated 11/11, indicated the resident had a left arm AV fistula.				
	There was a lack of documentation in the resident's service plan, dated 8/31/11, to indicate the resident had an AV fistula in her left arm.				
	During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated the AV fistula was not on the resident's service plan.				

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 67 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155572	A. BUILDING	00	CON	TE SURVEY MPLETED 20/2011
	ROVIDER OR SUPPLIE		10352 N	ADDRESS, CITY, STATE, ZIP ON 600 E COUNTY LINE TTE, IN 46310	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 68 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155572	B. WIN			12/20/2011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			N 600 E COUNTY LINE RD		
		ND REHAB CENTER	DEMOTTE, IN 46310				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
R0241	` '	ation of medications and the					
		ential nursing care shall be resident 's physician and					
		d by a licensed nurse on					
	the premises or or						
	-	all be administered by					
		ersonnel or qualified					
	medication aides.			Į			
	Based on observa	ation, record review, and	R02	241	R241 The facility is requesting	ıg	01/06/2012
	interview, the fac	cility failed to administer			paper compliance for this		
	•	rdered by a resident's			deficiency. The filing of this p		
		d to not administering the			of correction does not constitu	ıe	
		nedications and omitting			an admission that the alleged deficiency exists. This plan of	:	
		ions for 1 of 5 residents			correction is provided as		
					evidence of the facility's desire	e to	
	_	1 of 5 observations of			comply with the regulations ar		
		nistration passes.			continue to provide quality car		
	(Resident #105)				1) Immediate actions taken		
					for those residents identified		
	Findings include	:			Medication Error Reports wer		
					completed for Resident #105 a		
	During a medica	tion administration pass			physician was notified. 2) How the facility identified other	′	
	_	n RN #10 on 12/15/11 at			residents: Medication		
	· ·	0 prepared Resident			Administration Records of all		
	· ·	on, which included,			residents were reviewed since	;	
					12-1-11 and physicians notifie	d	
		lication for gout) 100 mg			as indicated. 2) Measures pu		
		o tablets daily at 8 a.m.,			into place/ System changes:		
	`	ent) 1,000 mg, four			Medical Records Director or		
	capsules daily at	8 a.m., and vitamin D			designee will audit Medication		
	(supplement) 50,	,000 units, one capsule			Administration Records weekly The Director of Nursing will	у.	
	two days per wee	_			perform a random medication		
					pass observation weekly on		
	RN #10 removed	I the medication cards			varied shifts. Issues identified	will	
					be addressed immediately. 4)		
		tion cart and placed one			How the corrective actions w	rill .	
	-	urinal 100 mg, one			be monitored: The results of t	the	
	capsule of fish of	il 1000 mg, and one			audits will be reviewed in the		
					monthly Quality Assurance		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 69 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTI A. BUILDIN B. WING		ONSTRUCTION 00	(X3) DATE COMPL 12/20/	ETED	
	PROVIDER OR SUPPLIEIN HILLS HEALTH A	R ND REHAB CENTER	10)352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	medication cup a	nin D in the plastic along with the resident's ns. RN #10 administered edications at 9:35 a.m.			meeting for a minimum of 6 months. 5) Date of compliance: 1/6/12		
	(MAR), dated 12	Administration Record 2/11, indicated the received the Vitamin D					
	observation, RN like the resident	wiew at the time of the #10 indicated it looked had not received the ecember of 2011.					
	a.m., RN #10 inc given two capsu four capsules of indicated the me						
	Vitamin D 50,00 10 a.m., indicate pharmacy on 10	nedication card for the 20 units, on 12/15/11 at ed the card was sent by /12/11 and the card had it. The card had seven out of the card.					
	indicated the res	IAR, dated 10/11, sident received the ctober 3, 5, 10, 12, 17,					

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 70 of 87

	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	20, and 27, 2011 (seven doses). The resident's MAR, dated 11/11, indicated the resident received the Vitamin D on November 3, 7, 10, 14, 17, 21, 24, and 28, 2011 (8 doses). The resident's MAR, dated 12/11, had no initials on the record to indicate the resident had received the dosages as ordered on December 1, 5, 8, and 12, 2011. During an interview on 12/16/11 at 8:45 a.m., the Director of Nursing indicated the Vitamin D was not being administered as ordered by the physician. She indicated the last medication card sent by the pharmacy was 10/02/11. Resident #105's record was reviewed on 12/16/11 at 7:25 a.m. The resident's diagnosis included, but was not limited to, Dementia. The resident's recapitulation physician's orders, dated 11/11, included physician orders for Allopurinal 100 mg, give two tablets daily at 8 a.m., fish oil 1,000 mg, give four capsules once daily at 8 a.m., and Vitamin D, 50,000 units, one capsule two days per week on Monday and Thursday at 8 a.m.	IAU		DATE

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 71 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
AUTUMN	ROVIDER OR SUPPLIER HILLS HEALTH AND REHAB CENTER	10352 N DEMOT	ADDRESS, CITY, STATE, ZIP COI N 600 E COUNTY LINE R ITE, IN 46310	D
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 72 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155572	B. WING		12/20/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD	
		ND REHAB CENTER		TTE, IN 46310	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG R0242		hall be observed for effects	TAG	DEFICIENCE!)	DATE
NU242	` '	ocumentation of any			
		s shall be contained in the			
		e physician shall be notified			
	-	lesirable effects occur, and			
	clinical record.	hall be documented in the			
!		review and interview, the	R0242	R242	01/06/2012
		monitor effects of a		The facility is requesting pa	per
	_	ntion, related to not taking		compliance for this deficien	cy.
	a blood pressure	daily as ordered, prior to		The filing of this plan of	
	administering blo	ood pressure medications,		correction does not constit	ute
	for 1 of 5 residen	nts reviewed for		an admission that the alleg	
	medications in a	sample of 5. (Resident		deficiency exists. This plan	·
	#110)	•		correction is provided as	
	,			evidence of the facility's de	
	Findings include	:		to comply with the regulation	ons
				and to continue to provide	
	Resident #110's 1	record was reviewed on		quality care.	
	12/15/11 at 12:30	0 p.m. The resident's			
	diagnoses includ	ed, but were not limited		1) Immediate actions take	en
	to, end stage rena	al disease and bipolar.		for those residents identified	d:
	The of the			Resident #110 no longer	
	1 2	recapitulation orders,		self-administers medication,	
		cated a physician's order		physician was notified and bloopressure is checked daily.	DOC
		(extended release)		prossure is dilected daily.	
	` •	medication) 90 mg		2) How the facility	
		re two capsules daily at		identified other residents	:
		hold if systolic blood			
	-	han 100 and metoprolol medication) 100 mg, give		Audit was completed of	
	` •	nes a day, hold if systolic		Medication Administration	
	blood pressure is	-		Records, and physicians	
	biood pressure is	icss than iv.		notified as needed.	
	A Medication Ac	dministration Record		3) Measures put into	

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 73 of 87

	OF CORRECTION OF CORRECTION 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
	PROVIDER OR SUPPLIER N HILLS HEALTH AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
	(MAR), dated 12/11, indicated the resident self-administers her medication after the staff sets up the medications weekly. The MAR indicated the diltiazem ER was scheduled for 8 p.m. The MAR indicated the metoprolol was scheduled for 9 a.m. and 5 p.m. There was a lack of documentation on the resident's MAR to indicate resident's blood pressure was monitored prior to the resident taking the blood pressure medications or monitored daily. There was a lack of documentation in the resident's Nurses' Notes to indicate the resident's blood pressure was monitored prior to taking the blood pressure medications or monitored daily. During an interview on 12/16/11 at 9:10 a.m., the Director of Nursing indicated the nurses were taking the resident's blood pressure daily, and just not writing it down. She indicated she did not ask the nurses if they were taking the blood pressure daily, but that she has observed them taking a blood pressure. She indicated she is not in the facility seven days a week.		Medical Records Director of designee will audit MAR' weekly. The Director of Nursing will perform a random medication pass observation weekly or varied shifts. Issues identified will be addressed immediately. 4) How the corrective actions will be monitored: The results of the audits will be reviewed in the monthly Quality Assurance meeting a minimum of 6 months. 5) Date of compliance: 1/6/13	s on n

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 74 of 87

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 12/2	TE SURVEY SPLETED 20/2011
	ROVIDER OR SUPPLIER I HILLS HEALTH A	ND REHAB CENTER	10352 N	ADDRESS, CITY, STATE, ZIP N 600 E COUNTY LINI TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 75 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED			
AND PLAN	OF CORRECTION	155572	A. BUILDING	00	12/20/2011
		100072	B. WING		12/20/2011
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	N HILLS HFAI TH A	ND REHAB CENTER		N 600 E COUNTY LINE RD OTTE, IN 46310	
				T	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R0244	ļ	doses for more than one			
	(1) scheduled adn	ninistration is not permitted.			
	Based on record	review and interview, the	R0244	R244	01/06/2012
	facility failed to	ensure not more than 1		The facility is requesting par	•
	scheduled medic	ation administration was		compliance for this deficient	cy.
	prepared related	to the facility setting up		The filing of this plan of	
	medications for a	a week for 3 of 3		correction does not constitu	ute
	residents who se	If administer medications		an admission that the alleg	
	in a sample of 5.	(Residents #101, #107,		deficiency exists. This plan	n of
	and #110)			correction is provided as	
				evidence of the facility's de	•
	Findings include	:		to comply with the regulation	ons
				and to continue to provide	
	1. Resident #110	0's record was reviewed		quality care.	
	on 12//15/11 at 1	2:30 p.m. The resident's			
	diagnoses includ	ed, but were not limited		1) Immediate actions taken f	or
	to, end stage ren	al disease and bipolar.		those residents identified:	
				Residents #101, 107 and 110	no
	An evaluation of	Tthe resident's ability to		longer self-administer	110
	safely self-admir	nister medication, dated		medications as of 12/16/11.	
	07/29/11, indicat	ted, the resident could		1	
	safely self-admir	nister her medications.		2) How the facility identified	ed
				other residents:	
	A Medication A	dministration Record,		No other residents	
	dated 12/11, indi	cated the resident		self-administer pre-set	
	self-administers	her medication after the		medications.	
	staff sets up the	medications weekly.			
				3) Measures put into place	e/
		1's record was reviewed		System changes:	
		:20 p.m. The resident's			
	_	ed, but were not limited		The facility no longer sets u	
	to, hypertension	and chronic obstructive		medications for residents to	
	pulmonary disea	se.		self administer. A licensed nurse or QMA administers	
				medications when medicati	ions
	I		1	Timedications when medicati	0110

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 76 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION OO		(X3) DATE SURVEY COMPLETED	
		155572	A. BUI B. WIN	LDING		12/20/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R			N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	TE, IN 46310	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE
		f the resident's ability to			are scheduled to be given.	
	1 *	nister medication, dated			The Director of Nursing will	
	· · · · · · · · · · · · · · · · · · ·	ted, "if the nurse			perform a random medicati	
		ines that the resident is			pass observation weekly or	
	not capable of se	C			varied shifts to ensure	
	_	plain heredue to his hx holism, this writer does			medications are being	
	not feel he is safe				administered by a licensed	
	not reer he is sar	ᠸ.			nurse or QMA.	
	The resident's M	edication Administration			4) How the corrective	
	Record, dated 12	2/11, indicated the			actions will be monitored:	1
		administering the				
	medications after	· ·			The results of these audits	
	medications wee	-			be reviewed in the monthly	
		•			Quality Assurance meeting a minimum of 6 months.	TOT
	3. Resident #107	's record was reviewed			a minimum of o months.	
	on 12/15/11 at 1:	:55 p.m. The resident's			5) Date of compliance: 1/6/1	12
	diagnoses includ	led, but were not limited				
	to, congestive he	eart failure and anemia.				
		f the resident's ability to				
	1	nister medication, dated				
	· ·	ted, the resident could				
	safely self-admir	nister her medications.				
	A Medication A	dministration Record,				
		icated the resident				
	•	his medication after the				
		medications weekly.				
	During on inter-	iow on 19/15/11 at 19:25				
	_	iew on 12/15/11 at 12:35 dicated the night shift				
	1	· ·				
	_	resident's medications nedication cassette.				
	ioi a week iii a n	neureation cassette.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155572	A. BUILDING	00	12/20/2011
			B. WINGSTREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			N 600 E COUNTY LINE RD	
		ND REHAB CENTER	DEMOT	TE, IN 46310	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
			1111		

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 78 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155572	B. WIN			12/20/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
		UD DELLAD GENTED			N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER		DEMO	ΓΤΕ, IN 46310	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
R0298	(2) A consultant pl	harmacist shall be er contract, and shall:				
		e for the duties as specified				
	in 856 IAC 1-7;	. for the duties as specified				
		g handling and storage				
	practices in the fac					
		Itation on methods and				
	procedures of orde	ering, storing, I disposing of drugs as well				
	as medication reco					
		ng, to the administrator or				
		e any irregularities in				
		ninistration of drugs; and				
		g regimen of each resident rvices at least once every				
	sixty (60) days.	i vices at least office every				
'	1	review and interview, the	R02	.98	R298	01/06/2012
		ensure a consultant			The facility is requesting pap	
	*	wed a resident's drug			compliance for this deficienc	;y.
	1 ^	once every sixty days for				
	•	reviewed for pharmacy			The filing of this plan of	
		s in a sample of 5.			correction does not	
	(Resident #113)	s in a sample of 5.			constitute an admission th	iat
	(Resident #113)				the alleged deficiency exists. This plan of	
	Findings include				correction is provided as	
	Tillulings illerude	•			evidence of the facility's	
	Dogidant #112's	record was reviewed on			desire to comply with the	
		p.m. The resident's			regulations and to continu	ıe
		•			to provide quality care.	
	•	ed, but were not limited				
	'	and anxiety. The resident				
	was admitted into	o the facility on 07/15/05.			1) Immediate actions taken those residents identified:	for
	The facility staff	were responsible for				
	administering Re	•			Unable to correct past deficien cited for Resident #113.	icy
	medications.				GREGIOI NESIGERE #113.	
					2) How the facility identified	Í
	The resident's ph	ysician's recapitulation			other residents:	
	Ī		1		Î.	1

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 79 of 87

IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/20/2011
ROVIDER OR SUPPLIER	ND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
SUMMARY S' (EACH DEFICIEN REGULATORY OR orders, dated 06/ pharmacist revie regimen on 06/03 A Medication Re indicated the nex on 12/01/11. During an interval	ND REHAB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 11, indicated a consultant wed the residents drug	10352	N 600 E COUNTY LINE RD	ential as men e ch

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 80 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUM DDIG	00	COMPLETED
		155572	A. BUILDING		12/20/2011
			B. WING		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
				N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER	DEMO	TTE, IN 46310	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROVIDENIA NA AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R0349	(a) The facility mu	st maintain clinical records			
	• •	These records must be			
		the supervision of an			
	employee of the fa	acility designated with that			
	responsibility. The	e records must be as			
	follows:				
	(1) Complete.				
	(2) Accurately dod				
	(3) Readily access				
	(4) Systematically		D0240	R349	01/07/2012
		review and interview, the	R0349	The facility is requesting page	01/06/2012
	_	ensure residents' records		compliance for this deficient	
	were complete a	nd accurate related to		compliance for this deficient	,y.
	service plans, we	eekly vital signs, and a		The filing of this plan of	
	mental health as	sessment for 3 of 5		correction does not constitu	ıte
	resident's medica	al records reviewed in a		an admission that the allege	
		sidents #107, and #110)		deficiency exists. This plan	
	sample of 3. (Re	sidents #107, and #110)		correction is provided as	101
				evidence of the facility's de	oiro
	Findings include	:		to comply with the regulation	
					1115
	1. Resident #10	7's record was reviewed		and to continue to provide	
	on 12/15/11 at 1	:55 p.m. The resident's		quality care.	
		led, but were not limited			
	_	eart failure and anemia.		1) Immediate actions take	n
	to, congestive ne	cart fariate and anomia.		for those residents identified	
	and .			lor those residents rachtimes	•
		dated and not signed		Resident #107: The	
	Service/Function	nal Assessment in the		Service/Functional Assessme	nt
	resident's record			was signed and dated. Physic	ian
				was notified of vital signs not	
	The resident's A	ssessment & Service Plan		documented on the dates	
	was undated.			identified.	
	was undated.			 	
				Resident #110: A new mental	
		mation was provided by		health screen was completed	l l
	,	gard to the resident's		accurately reflect mood disord	ICI.
	undated and uns	igned forms in the record		2) How the facility identific	ad
	as of 12/15/11 at			2) How the facility identified	54

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 81 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155572	B. WIN	G		12/20/2011
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE	
					N 600 E COUNTY LINE RD	
AUTUMN	I HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN 46310	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					other residents:	
		recapitulation orders,			Madication Administration	
	•	icated an order, dated			Medication Administration Records of all residents we	ro
	· ·	ain a full set of vital signs			reviewed and physicians	16
	weekly on Tueso	lays.			notified as indicated.	
					Tiotilioù do ilidioatoù.	
	The resident's M	edication Administration			All Service Functional	
	Record (MAR),	dated 10/11, indicated the			Assessments were audited,	,
	vital signs were	not obtained on October			no other residents were	
	4, 18, and 25, 20	11.			affected.	
	The resident's M	AR, dated 12/11,			Social Service Director	
	indicated the vita	al signs were not obtained			audited all mental health	
	on 12/06/11.				screens to ensure information	on
					was accurate.	
	During an interv	iew on 12/16/11 at 9:40			2) Mossures put into	
	_	or of Nursing indicated		3) Measures put into place/ System changes:		
	· ·	(blank spaces) on the			piace/ Cystem changes.	
		cated the staff were not			 Medical Records Director o	r
		ting the vital signs.			designee will audit Medicati	
		and the time signs.			Administration Records at	
	2 Resident #110	0's record was reviewed			least once weekly.	
		2:30 p.m. The resident's				
		led, but were not limited			Medical Records Director o	r
	1	al disease and bipolar.			designee will audit new	
	to, chu stage fell	ai discase and dipolar.			admission charts within 72	
	A mental health	screening form, dated			hours of admission to ensure all required assessments are	
		ted the resident did not			paperwork are completed a	
	· · · · · · · · · · · · · · · · · · ·	d major mental illness.			filed in charts and every 6	
		3			months thereafter.	
		ck mark next to, "none".				
	Wood disorder w	vas not checked (bipolar).			Social Service Director will	
		10/1/2/14			audit mental health screens	;
	_	iew on 12/16/11 at 11:40			upon admission and every (6
	a.m. the Social S	Service Director indicated			months to ensure	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155572	A. BUILDING B. WING	00	COMPLETED 12/20/2011
	ROVIDER OR SUPPLIER	ND REHAB CENTER	10352	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	mood disorder sh	LSC IDENTIFYING INFORMATION) nould have been checked. resident was receiving		information is accurate. 4) How the corrective actions will be monitored: The results of these audits be reviewed in the monthly Quality Assurance meeting a minimum of 6 months. 5) Date of compliance: 1/6/12	will

State Form Event ID: 719511 Facility ID: 000471 If continuation sheet Page 83 of 87

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00			COMPLETED	
		155572	B. WING 12/20/2011				2011	
					ADDRESS, CITY, STATE, ZIP CODE	L		
NAME OF I	PROVIDER OR SUPPLIER	L		l	N 600 E COUNTY LINE RD			
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER			ΓΤΕ, IN 46310			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	<u> </u>	DATE	
R0356		gency information file shall						
	_	cessible for each resident,						
	following:	ncy, that contains the						
	•	s name, sex, room or						
		r, phone number, age, or						
	date of birth.							
		s hospital preference.						
		phone number of any						
	legally authorized	•						
	resident 's physic	phone number of the						
		telephone number of the						
		r other persons to be						
		vent of an emergency or						
	death.							
		any known allergies.						
		(for identification of the						
	resident). (8) Copy of advan	ce directives, if available.						
	1	review and interview, the	R03	56	 R356	 	01/06/2012	
		ensure an emergency	K0550		The facility is requesting paper		01/00/2012	
	information file	• •			compliance for this deficiency.			
		of 5 residents reviewed						
					The filing of this plan of			
		les in a sample of 5.			correction does not constitute			
	(Resident #107)				an admission that the allege			
					deficiency exists. This plan	of		
	Findings include	:			correction is provided as	_:		
					evidence of the facility's des			
	Resident #107's i	record was reviewed on			to comply with the regulation and to continue to provide	iis		
	12/15/11 at 1:55	p.m. The resident's			quality care.			
	diagnoses includ	ed, but were not limited			quality care.			
	to, congestive he	eart failure and anemia.						
		admitted into the facility			1) Immediate actions take	n		
	on 07/05/11.				for those residents identified	:		
	211 0 , , 00 , 111.							
	The resident's rea	cord lack documentation			Resident #107: Information			
		sident had an emergency			required was placed in			
	i to mulcate the le	SIGOIL HAG AH CHICI GCHCY	1		Emergency File.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED		
		155572	B. WING		12/20/2011	
				ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIE	R		N 600 E COUNTY LINE RD		
ΔΙΙΤΙΙΜΝ	J HILLS HEALTH A	AND REHAB CENTER		TTE, IN 46310		
				T 1 E, 114 400 10		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	file.					
				2) How the facility identified	ed	
	The three ring binder, kept at the Nurses'			other residents:		
	_	, "Emergency Files",				
		ntation to indicate the		An audit was completed of	the	
				Emergency File for all		
	resident had an	emergency file.		residents, and no other		
				residents were affected.		
	During an interv	view on 12/15/11 at 12:50				
	a.m., the Medica	al Records LPN indicated		3) Measures put into place	e/	
	the resident did not have an emergency			System changes:		
	file.			'		
	inc.			Medical Records Director of	r	
				designee will audit the		
				Emergency File within 72		
				hours for new admissions, and		
				every 6 months thereafter t		
				ensure required information		
				110		
				present and accurate.		
				4) How the corrective		
				actions will be monitored:		
				actions will be monitored.		
				The manufacture of the construction		
				The results of these audits		
				be reviewed in the monthly		
				Quality Assurance meeting	tor	
				a minimum of 6 months.		
				5) Date of compliance: 1/6/1	2	
1					1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 12/20/2011			
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
R0383	providers, shall de careplan for the refollowing: (1) Psychosocial rare to be provided (2) A comprehens meet multiple lever following: (A) Recreational at (B) Social skills. (C) Training, occuprograms. (D) Opportunities restrictive and moarrangements. Based on record facility failed to careplan with the providers for 1 of for mental health (Resident #110) Findings included Resident #110's 12//15/11 at 12:3 diagnoses included to, end stage renumber A mental health 01/13/11, indicated have a diagnose of There was a check.	the mental health service evelop the comprehensive evelop the comprehensive evelop the comprehensive evelop the comprehensive evelop that includes the evental within the community. Sive range of activities to els of need, including the evelop and socialization activities. Inpational, and work for progression into less are independent living review and interview, the develop a comprehensive evental health service of 5 residents reviewed in disease in a sample of 5.	R0383	R383 The facility is requesting pacompliance for this deficient. The filing of this plan of correction does not constit an admission that the alleg deficiency exists. This placorrection is provided as evidence of the facility's deto comply with the regulation and to continue to provide quality care. 1) Immediate actions take for those residents identified. Resident #110: A new mental health screen was completed accurately reflect mood disornand a comprehensive care playing the mental health services provider was placed in chart.	ute ged n of esire ons en d: l to der an		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE SI COMPLE 12/20/2	TED
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS HEALTH AND REHAB CENTER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The resident's se 08/31/11, lacked comprehensive of health service produced by the service produced by	rvice plan, dated documentation of a careplan with the mental oviders. iew on 12/16/11 at 11:40 Service Director indicated nould have been checked. The resident was receiving rvices. She indicated nental health careplan in ord. iew on 12/16/11 at 12:35 Service Director d the mental health fax over a client			CROSS-REFERENCED TO THE APPROPRIA	ed on lith lith will	
					5) Date of compliance: 1/6/12		

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